

EXHIBIT 1

AFFIDAVIT OF AMANDA GRIFFIN

STATE OF ARKANSAS §
§
BENTON COUNTY §

BEFORE ME, the undersigned authority, on this day personally appeared Amanda Griffin, who, being by me duly sworn according to law, deposed and said:

1. "My name is Amanda Griffin. I have never been convicted of a felony or a crime of moral turpitude. I am over 18 years of age, of sound mind, and competent to make this affidavit. I have personal knowledge of the facts contained in this affidavit and they are true and correct. I am currently employed in the position of Senior Director of Shared Services for Walmart Stores, Inc. In this capacity I am a custodian of the records generated by Shared Services, including the development and content of the various Computer Based Learning Modules (CBL's) utilized throughout Wal-Mart retail locations.

2. Attached as Exhibit "A-B" to Defendant's Motion to Compel Arbitration are 80 pages of records that are maintained in the ordinary course of business, and it was the ordinary course of business for an employee with knowledge of the act, event, condition, or opinion, to make the record and transmit information thereof to be included in such record, and the record was made at or near the time of reasonably soon thereafter. The records attached hereto are the originals or exact duplicates of the originals.

3. On March 1, 2012, the Walmart Stores, Inc., Texas Injury Care Benefit Plan, an alternative to workers' compensation, became effective for associates (employees) who sustain injuries in the course and scope of their employment. Walmart Stores, Inc. is the Plan Sponsor of Texas Injury Care Benefit Plan.

4. All associates working in Texas are required to complete certain Computer Based Learning (CBL) modules. The CBL modules are paperless and are accessed through computers at the Walmart location by the associate entering his or her confidential associate identification number and password. Once a module is completed by an associate, an electronic training record is retained which identifies the date the module was completed, the completion status, and the score, if the module requires a test.

5. One of the training modules required of CBL associates working in Texas is a CBL titled Texas Injury Care Benefit Plan. In general, the Texas Injury Care Benefit Plan CBL trains associates on the benefits under the Texas Injury Care Benefit Plan, the associate's responsibilities for reporting an injury, the supervisor's requirements, the process to receive benefits, the process for appeal if benefits are denied under the Texas Injury

AFFIDAVIT OF AMANDA GRIFFIN - PAGE 1

Care Benefit Plan and mandatory arbitration for work related injuries. Attached as Exhibit "A" to Defendant's Motion to Compel Arbitration are true and correct copies of the training modules regarding Walmart's Texas Injury Care Benefit Plan.

6. The Texas Injury Care Benefit Plan CBL has a section titled Arbitration that informs associates that the Plan has a mandatory arbitration process to resolve disputes other than benefit claims.

7. The Texas Injury Care Benefit Plan CBL also has a section titled Summary Plan Description which informs associate that he or she can access the Summary Plan Description by clicking on a particular button. Associates must click the link to the plan and review it before continuing to the next page. A true and correct copy of Walmart's Summary Plan Description is attached as Exhibit "B" to Defendant's Motion to Compel Arbitration.

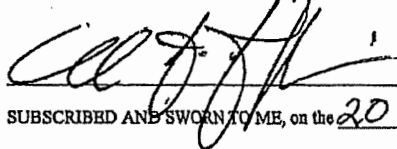
8. Moreover, the Texas Injury Care Benefit Plan CBL has a section titled Important Acknowledgments which informs associates that the purpose of this program is to make sure that the associate is aware of and understands his or her rights and obligations regarding the Texas Injury Care Benefit Plan. The Important Acknowledgements section further informs the associates that the current screen and the following two screens contain critical information and links regarding arbitration that must be read in order to receive credit for completing this module. More specifically, the Important Acknowledgement section informs the associate that the arbitration policy may be accessed by clicking the following button, that it is important for the associate to read the policy carefully so that the associate will be aware of his or her rights and obligations regarding arbitration, and to click the button and read this policy carefully before continuing. An associate may not continue through the module without first clicking this button.

9. The Texas Injury Care Benefit Plan CBL further has a section titled Arbitration Acknowledgement which informs the associate to please read the information of this screen and when finished, click "I Understand" in order to proceed. An associate may not continue through the module without first clicking this button.

10. Finally, the Texas Injury Care Benefit Plan CBL has a section titled Acknowledgement of Completion which informs the associate that by clicking on the button below, the associate is completing the course and acknowledging the associate has read and understood the Arbitration Acknowledgement and Policy and that the associate understands his or her rights and obligations under the Walmart and Sam's Club Texas Injury Care Benefit Plan. The Acknowledgment of Completion section lastly informs the associate that his or her training record will be updated to show that the associate has successfully completed this course.

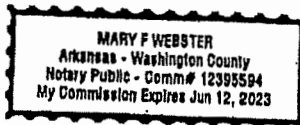
11. Furthermore, Appendix A, Arbitration of Certain Injury Related Disputes, informs associates that the binding arbitration will be the sole and exclusive remedy for resolving work-related injury claims or disputes. More specifically, Appendix A, Arbitration of Certain Injury Related Disputes, Paragraph (b)(1) states that this policy applies to each associate and the Employer without regard to whether they have completed and signed a Receipt, Safety Pledge and Arbitration Acknowledgment form or similar written receipt. This paragraph further states that adequate consideration for this Policy is represented by, among other things, eligibility for (and not necessarily any receipt of) benefits under this Plan and the fact that it is mutually binding on both the Employer and associates. This paragraph continues to state that any actual payment of benefits under this Plan to or with respect to an associate shall serve as further consideration for and represent the further agreement of such associate to the provisions of this Policy.

"FURTHER AFFIANT SAYETH NOT:"



AMANDA GRIFFIN

SUBSCRIBED AND SWORN TO ME, on the 20 day of April, 2015, to certify which witness my
and and official seal..



My Commission Expires: 06/12/23

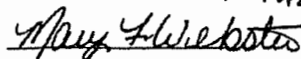
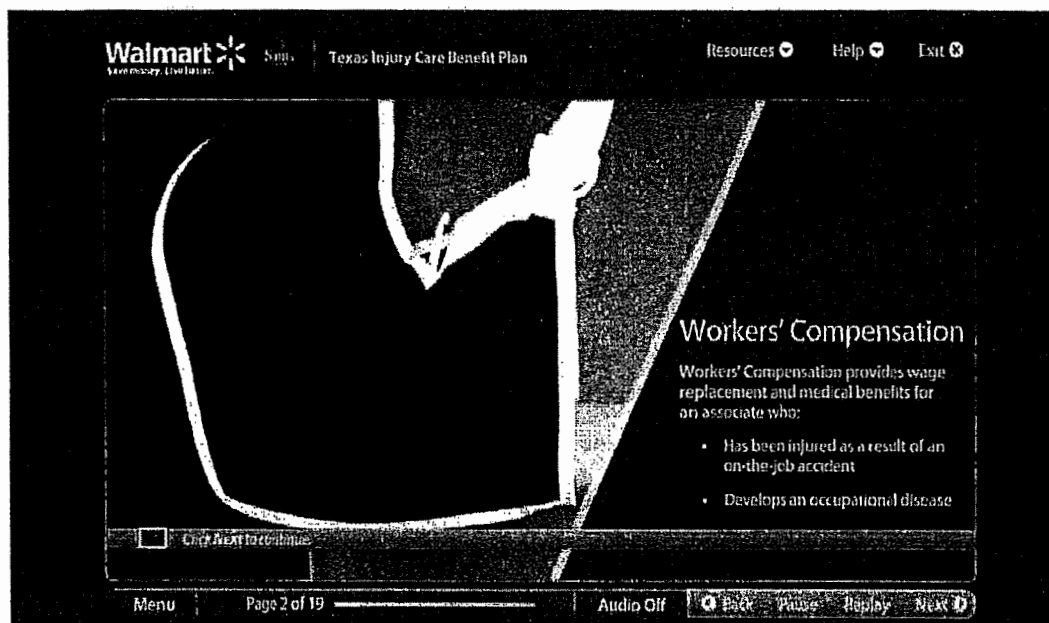
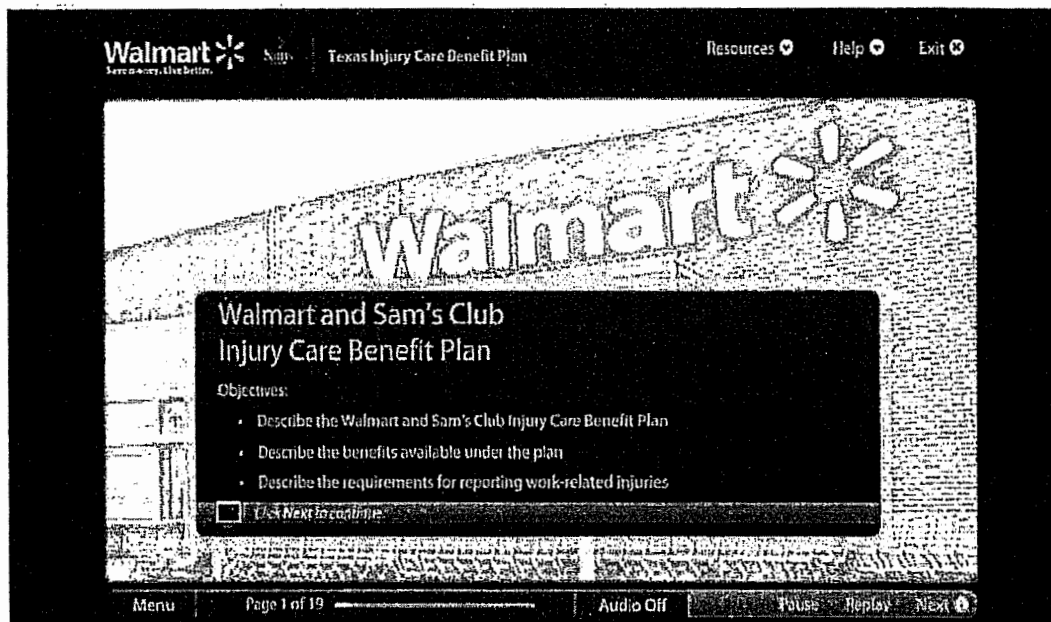



EXHIBIT 1A



Walmart  Save money. Live better. Sam's Texas Injury Care Benefit Plan Resources Help Exit

Walmart and Sam's Club Injury Care Benefit Plan


The new Walmart and Sam's Club Texas Injury Care Benefit Plan is designed to:

- Increase the pool of qualified physicians and medical facilities available to treat work-related injuries
- Provide medically appropriate and more timely treatment of injuries
- Provide excellent occupational injury benefits
- Allow associates to get healthy faster and return to work sooner
- Reduce red tape and paperwork

☐ Click Next to continue

Menu Page 3 of 19 Audio Off Back Pause Replay Next

This slide features a background image of a Walmart store interior with a "\$10" sign visible on the left.

Walmart  Save money. Live better. Sam's Texas Injury Care Benefit Plan Resources Help Exit






Walmart and Sam's Club Texas Injury Care Benefit Plan

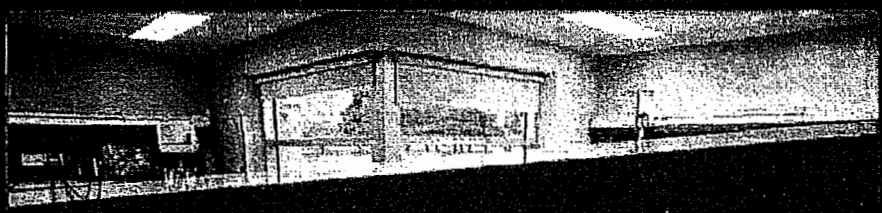
- The Walmart and Sam's Club Texas Injury Care Benefit Plan is not Workers' Compensation.
- The plan covers all Texas associates, for on-the-job injuries or occupational illnesses.
- There is no cost to associates for the Walmart and Sam's Club Texas Injury Care Benefit Plan.

☐ Click Next to continue

Menu Page 4 of 19 Audio Off Back Pause Replay Next

This slide features a background image of a Walmart store interior with a desk and a computer monitor visible on the right.





Walmart  Sam's  Texas Injury Care Benefit Plan Resources  Help  Exit 








Texas Injury Care Benefit Plan

- The Texas Injury Care Benefit Plan pays for covered medical care through approved medical providers.
- Approved physicians, hospitals and clinics must be used for medical treatment.
- If an approved physician restricts you from your normal work schedule due to an on-the-job injury, wage or salary benefits may be available to you.


☐ Click Next to continue.

Menu Page 5 of 19 Audio Off    


Walmart  Sam's  Texas Injury Care Benefit Plan Resources  Help  Exit 





Summary of the Walmart and Sam's Club Texas Injury Care Benefit Plan


Here we will summarize the benefits that are available under the Walmart and Sam's Club Texas Injury Care Benefit Plan.

-  ☒ Maximum Benefit Limit
- ☒ Medical Benefits
- ☒ Wage Replacement Benefits
- ☒ Death Benefits
- ☒ Dismemberment Benefits

☐ Click each benefit to find out more. When you are ready, click Next to continue.




Menu Page 6 of 19 Audio Off    

Walmart  Save money. Live better. | Sam's | Texas Injury Care Benefit Plan | Resources | Help | Exit

Summary of the Walmart and Sam's Club Texas Injury Care Benefit Plan

Here we will summarize the benefits that are available under the Walmart and Sam's Club Texas Injury Care Benefit Plan.

- ☐ **Medical Benefits**
- ☒ **Wage Replacement Benefits**
- ☐ **Death Benefits**
- ☐ **Dismemberment Benefits**



Maximum Benefit Limit

The maximum amount for all benefits combined, payable to an associate for an injury: \$300,000 per claim; \$1,000,000 per occurrence.

☐ Click each benefit to find out more. When you are ready, click Next to continue.

Menu | Page 6 of 19 | Audio Off | Back | Pause | Replay | Exit

Walmart  Save money. Live better. | Sam's | Texas Injury Care Benefit Plan | Resources | Help | Exit

Summary of the Walmart and Sam's Club Texas Injury Care Benefit Plan

Here we will summarize the benefits that are available under the Walmart and Sam's Club Texas Injury Care Benefit Plan.

- ☒ **Maximum Benefit Limit**
- ☐ **Medical Benefits**
- ☐ **Wage Replacement Benefits**
- ☐ **Death Benefits**
- ☐ **Dismemberment Benefits**




Medical Benefits

Pay for care from approved health care providers if associate is injured at work: 100% of covered charges for up to 120 weeks or the maximum benefit.

☐ Click each benefit to find out more. When you are ready, click Next to continue.


Menu | Page 6 of 19 | Audio Off | Back | Pause | Replay | Exit

Walmart  Save money. Live better. Sam's Club Texas Injury Care Benefit Plan Resources Help Exit

Summary of the Walmart and Sam's Club Texas Injury Care Benefit Plan

Here we will summarize the benefits that are available under the Walmart and Sam's Club Texas Injury Care Benefit Plan.

- Maximum Benefit Limit
- Medical Benefits
- Wage Replacement Benefits
- Death Benefits
- Dismemberment Benefits




Wage Replacement Benefits

Pay Income reimbursement. If associate needs time at home to recover. Starting on the first full day of disability, it pays 90% of an associate's lost wages for up to 120 weeks or the benefit maximum.

☐ Click each benefit to find out more. When you're ready, click Next to continue.


Menu Page 6 of 19 Audio Off Back Pause Replay

Walmart  Save money. Live better. Sam's Club Texas Injury Care Benefit Plan Resources Help Exit

Summary of the Walmart and Sam's Club Texas Injury Care Benefit Plan

Here we will summarize the benefits that are available under the Walmart and Sam's Club Texas Injury Care Benefit Plan.

- Maximum Benefit Limit
- Medical Benefits
- Wage Replacement Benefits
- Death Benefits
- Dismemberment Benefits





Death Benefits

If death occurs as a result of an on the job injury the benefit is up to \$250,000.

☐ Click each benefit to find out more. When you're ready, click Next to continue.


Menu Page 6 of 19 Audio Off Back Pause Replay

Walmart  Sam's  Texas Injury Care Benefit Plan Resources Help Exit

Summary of the Walmart and Sam's Club Texas Injury Care Benefit Plan

Here we will summarize the benefits that are available under the Walmart and Sam's Club Texas Injury Care Benefit Plan.

- Maximum Benefit Limit
- Medical Benefits
- Wage Replacement Benefits
- Death Benefits
- ☐ [Click here to learn more about the plan.](#)




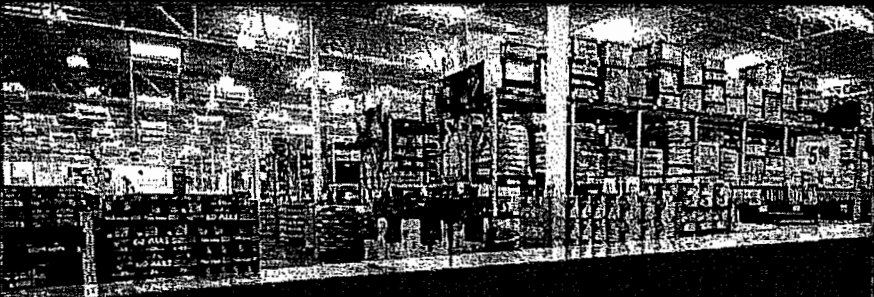
Disability Benefits

Provide a payment for total loss or loss of use of a body member; up to \$250,000 paid, based upon the severity of the injury (20% down and remainder over 35 months).

☐ [Click here to learn more about the plan.](#) When you are ready, click Next to continue.

Menu Page 6 of 19 Audio Off Back Pause Play Next

Walmart  Sam's  Texas Injury Care Benefit Plan Resources Help Exit







Associate Responsibilities


You **MUST** report all on-the-job injuries within 24 hours, no matter how minor the injury.

- Tell your immediate supervisor.
- Failure to report an injury within 24 hours will likely result in loss of benefits.

☐ [Click Next to continue.](#)

Menu Page 7 of 19 Audio Off Back Pause Play Next

Walmart  Savings **Texas Injury Care Benefit Plan** Resources  Help  Exit 











Supervisor Requirement for the Walmart and Sam's Club Texas Injury Care Benefit Plan


A supervisor who receives notice of an injury to an associate must immediately:

- Report the injury online by logging onto the WIRE and using the Incident Reporting System.
- Report the injury to Risk Management.

☐ Click Next to continue.

Menu Page 8 of 19 Audio Off    





Walmart  Savings **Texas Injury Care Benefit Plan** Resources  Help  Exit 



How to Receive Benefits

- You must use medical providers and facilities approved by the Walmart and Sam's Club Texas Injury Care Benefit Plan.
- Approved providers and facilities will be posted at each location.
- You must seek initial medical treatment within 14 days from the date of the injury.

☐ Click Next to continue.

Menu Page 9 of 19 Audio Off    

Walmart  Save money. Live better. | Texas Injury Care Benefit Plan | Resources | Help | Exit


Associate Responsibilities

Until released for work, you must:

- Follow the doctor's orders
- Keep all scheduled appointments
- Obtain a copy of the completed Work Status Form and return it to Management each time you visit a physician

☐ Click Next to continue.

Menu | Page 10 of 19 | Audio Off | Back | Pause | Replay | Next

Walmart  Save money. Live better. | Texas Injury Care Benefit Plan | Resources | Help | Exit


Review


In order to receive benefits you must:

- Report the injury to a supervisor on duty no later than 24 hours after the accident occurs
- Use only medical providers as approved by the Plan, unless the injury results in an emergency
- Receive initial medical treatment with an approved medical provider no later than 14 days from the date of an injury

☐ Click Next to continue.

Menu | Page 11 of 19 | Audio Off | Back | Pause | Replay | Next

Walmart  Save money. Live better. | Texas Injury Care Benefit Plan | Resources | Help | Exit




Appeals Process


A formal appeal may be made through an Appeals Committee. If an appeal is submitted, the Appeals Committee will:

- Review your appeal of an initial denial of benefits determination.
- Review the claim and any additional information you can provide.
- Forward a determination to you advising you of the committee's decision usually within 30 or 45 days, depending upon the type of request made.

☐ Click Next to continue.

Menu | Page 12 of 19 | Audio Off | Back | Pause | Replay | Next

Walmart  Save money. Live better. | Texas Injury Care Benefit Plan | Resources | Help | Exit



Arbitration

Arbitration is a process where a neutral party is engaged to hear both sides of an issue and make a binding decision.

The advantages of arbitration are:

- Protected rights: It has the same fundamental protections as a court of law.
- Fast decisions: Rather than taking years to resolve a dispute through a court, arbitration can usually result in a decision in a few months.
- Fair decisions: Together, the associate and Walmart or Sam's Club select a professional arbitrator who specializes in work-related problems.

☐ Click Next to continue.

Menu | Page 13 of 19 | Audio Off | Back | Pause | Replay | Next

Walmart  Sam's  Texas Injury Care Benefit Plan Resources  Help  Exit 

Review

Let's review some of the key points of the Walmart and Sam's Club Texas Injury Care Benefit Plan that we have covered in this module.







Plan Highlights Associate Responsibilities Appeals and Arbitration

Click each image to find out more. When you are ready, click Next to continue.

Menu Page 14 of 19 Audio Off Back Pause Replay

Walmart  Sam's  Texas Injury Care Benefit Plan Resources  Help  Exit 

Review

Let's review some of the key points of the Walmart and Sam's Club Texas Injury Care Benefit Plan that we have covered in this module.









Plan Highlights Associate Responsibilities Appeals and Arbitration

Click each image to find out more. When you are ready, click Next to continue.

Menu Page 14 of 19 Audio Off Back Pause Replay

Walmart  Save money. Live better.  Texas Injury Care Benefit Plan Resources Help Exit


Review

Let's review some of the key points of the Walmart and Sam's Club Texas Injury Care Benefit Plan that we have covered in this module.


Associate Responsibilities

Associates must:


- Report on-the-job injuries within 24 hours.
- Seek medical treatment within 14 days of the date of the injury.
- Use approved physicians and providers, except in the case of a medical emergency.
- Follow the doctor's orders and keep all appointments.
- Provide a copy of a completed Work Status Form to Management after each appointment with a physician.



Plan Highlights





Associate Responsibilities



Appeals and Arbitration

Click each image to find out more. When you are ready, click Next to continue.

Menu Page 14 of 19 Audio Off Back Pause Display Next

Walmart  Save money. Live better.  Texas Injury Care Benefit Plan Resources Help Exit


Review

Let's review some of the key points of the Walmart and Sam's Club Texas Injury Care Benefit Plan that we have covered in this module.


Appeals and Arbitration

In addition to the basic coverage provided by the Walmart and Sam's Club Texas Injury Care Benefit Plan, an associate may also:


- Appeal benefits denial through an Appeals Committee.
- Engage a formal arbitration process to resolve disputes.



Plan Highlights



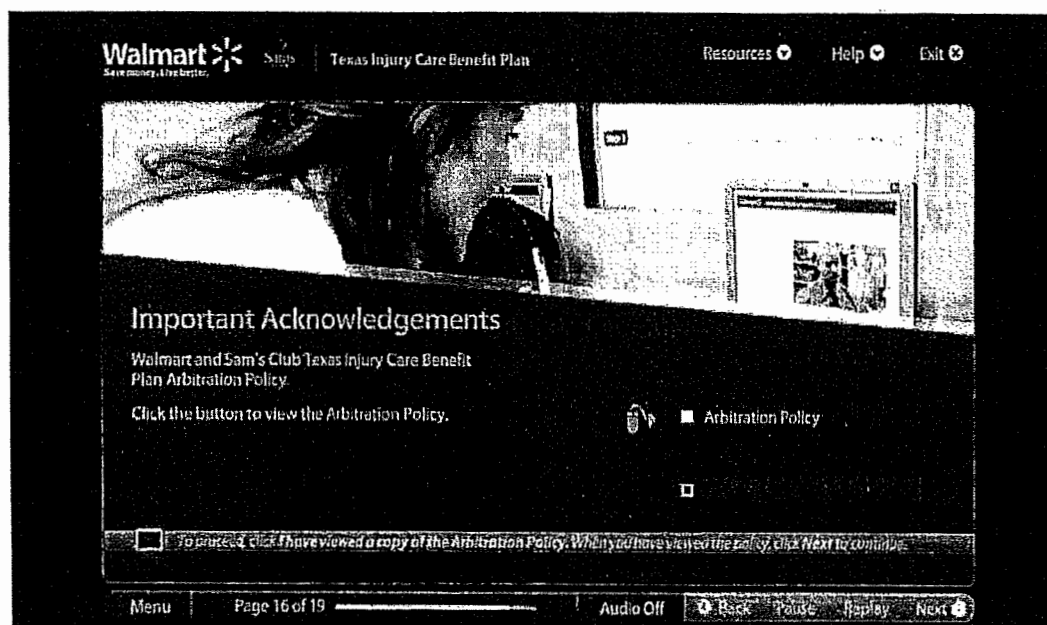
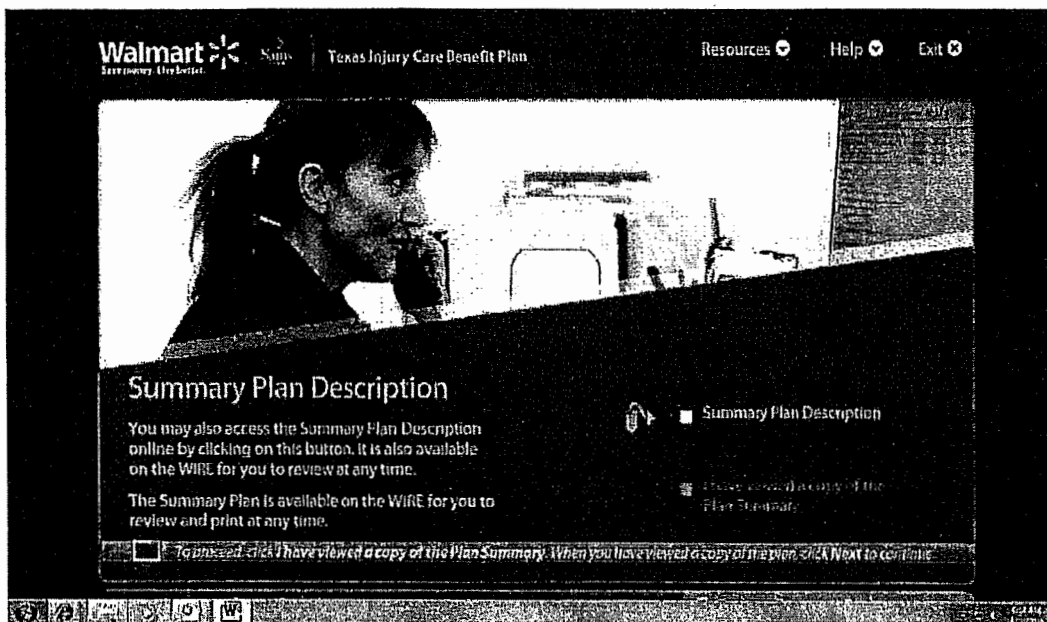
Associate Responsibilities

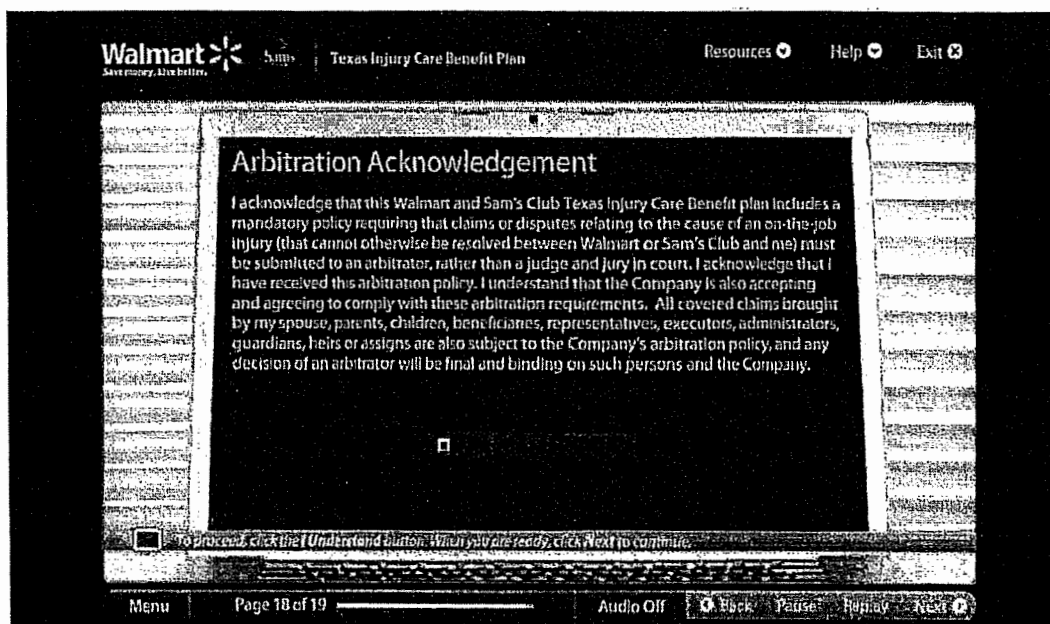
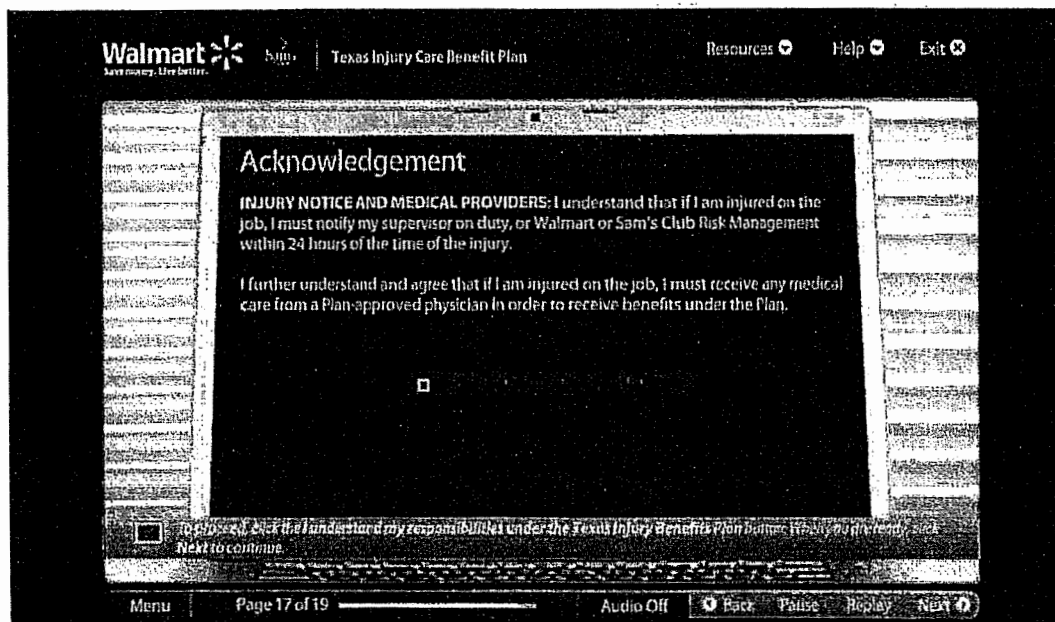



Appeals and Arbitration

Click each image to find out more. When you are ready, click Next to continue.


Menu Page 14 of 19 Audio Off Back Pause Display Next











Save money. Live better.



Texas Injury Care Benefit Plan


Resources  Help  Exit 







Acknowledgement of Completion


By clicking on the button below, you are completing the course and acknowledging the following:

1. You have read and understand the Arbitration Acknowledgement and Policy, and
2. You understand your rights and obligations under the Walmart and Sam's Club Texas Injury Care Benefit Plan.


 Course Completion

☐ To complete the course, click the **Course Completion** button.




Menu | Page 19 of 19 | Audio Off |  Back |  Pause |  Replay | 




Save money. Live better.



Texas Injury Care Benefit Plan

Resources  Help  Exit 



Acknowledgement of Completion

By clicking on the button below, you are completing the course and acknowledging the following:

1. You have read and understand the Arbitration Acknowledgement and Policy, and
2. You understand your rights and obligations under the Walmart and Sam's Club Texas Injury Care Benefit Plan.

Well done.
You have now completed the course.

☐ When you are ready, click the **Exit** button in the top right of the screen to close the module.





Menu | Page 19 of 19 | Audio Off |  Back |  Pause |  Replay | 

EXHIBIT 1B

WALMART STORES, INC.
TEXAS INJURY CARE BENEFIT PLAN
(Effective March 1, 2012)

SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

	<u>Page</u>
Program Highlights	1
Why is the Company starting this Plan?	1
Who is covered by the Plan?	1
How does the Plan affect me?	1
What are the advantages of the Plan?	1
Is there a waiting period before my wage replacement benefits will begin?	2
What are some of the requirements of the Plan?	2
How are benefit payments handled?	2
What if I am not satisfied with how my benefit claim is handled?	2
What if I have other issues related to my injury?	2
What are the advantages of arbitration?	3
Does this Plan directly affect my health insurance or other benefits?	3
When does this Plan take effect?	3
PLAN BENEFITS	4
Case Study	5
How does the Plan work?	5
Reporting an Injury	6
What should I do if I am injured on the job?	6
PROGRAM DETAIL	7
INTRODUCTION	7
NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION	
IN TEXAS	7
ELIGIBILITY	8
HOW THE PLAN WORKS	8
Procedure In Event Of Injury	8
Medical Determinations and Treatment	9
Funding	10
COVERED AND NON-COVERED INJURIES	11
Covered Injuries	11
Types of Non-Covered Injuries	12
Non-Covered Injury Circumstances	13
REQUESTING BENEFITS	15
Notice of Injury	15
Providing Required Information	15

	<u>Page</u>
MEDICAL BENEFITS	16
First and Continuing Treatment.....	16
Approved Provider and Pre-Authorization Requirements.....	16
Covered Medical Services and Supplies	17
Non-Covered Medical Services and Supplies	19
Initial Treatment and Denial	21
Medical Provider Referrals	21
No Interference with Patient-Provider Relationship.....	21
Second Medical Opinions.....	22
When Medical Benefits Cease	23
WAGE REPLACEMENT BENEFITS	23
When Wage Replacement Benefits Begin	23
When Wage Replacement Benefits Cease	24
Other Benefit Reductions	25
DEATH BENEFITS	25
DISMEMBERMENT BENEFITS	25
CONTINUING BENEFITS.....	27
DETAILED CLAIM PROCEDURES.....	28
Filing a Claim for Benefits	28
Claims Review Procedures	30
FINAL COMPROMISE AND SETTLEMENT	Error! Bookmark not defined.
OFFSET, REIMBURSEMENT, AND RECOVERY OF BENEFIT.....	35
Offset For Other Benefits	35
Coordination Of Benefits	36
Subrogation and Reimbursement Rights	37
Notice of Legal Proceedings	39
Assignment of Rights	39
Right To Receive And Release Necessary Information	40
APPLICABLE LAW	40
AMENDMENT OR TERMINATION OF PLAN	40
DEFINITIONS	41
Adverse Benefit Determination.....	41
Appeals Committee.....	41
Approved Facility.....	41
Approved Physician	41
Beneficiary	41
Claims Administrator	42
Course and Scope of Employment.....	42

	<u>Page</u>
Disabled or Disability.....	43
Emergency Care	44
Maximum Benefit Limit.....	44
Maximum Rehabilitative Capacity	44
Plan	44
Plan Administrator.....	44
Post-Service Claim.....	45
Preexisting Condition	45
Pre-Injury Pay	45
Pre-Service Claim	46
Representative	46
Receipt, Safety Pledge and Arbitration Acknowledgement	46
Temporary Alternative Duty.....	46
Urgent Care Claim	46
Violent Crime.....	47
GENERAL INFORMATION	47
Type Of Plan and Administration.....	47
Name And Address Of Primary Plan Sponsor.....	47
Name and Address Of Plan Administrator.....	47
Name And Address Of Person Designated As Agent For Service Of Legal Process.....	48
Employer And Plan Identification Numbers	48
Plan Year	48
COBRA RIGHTS STATEMENT.....	48
ERISA RIGHTS STATEMENT	48
Receive Information About Your Plan and Benefits	48
Continue Group Health Plan Coverage.....	49
Prudent Actions by Plan Fiduciaries.....	49
Enforce Your Rights	49
Assistance with Your Questions	49
APPENDIX A: ARBITRATION OF CERTAIN INJURY-RELATED DISPUTES	
APPENDIX B: PARTICIPATING EMPLOYERS	
APPENDIX C: COBRA CONTINUATION COVERAGE NOTICE	
APPENDIX D: RECEIPT, SAFETY PLEDGE AND ARBITRATION ACKNOWLEDGEMENT	

Program Highlights

Why is the Company starting this Plan?

Maintaining and improving our culture of safety is a priority at Walmart. But, in the event a work-related injury occurs, we want to be certain Walmart Associates have access to quality physicians and receive prompt, fair, and excellent care. This is why Walmart Stores, Inc. (the "Company") has created the Walmart Stores, Inc. Texas Injury Care Benefit Plan (the "Plan").

The benefits under the Texas Workers' Compensation System are determined by the State. By opting out of the State program, Walmart can improve the benefits most meaningful to Walmart associates and gain access to physicians who will not treat Workers Compensation patients. Many other businesses across Texas have adopted similar programs for their associates. Walmart is excited to be able to offer this new benefit to its Associates.

Who is covered by the Plan?

All Texas associates of Walmart Stores, Inc., Sam's East, Inc., Walmart Associates, Inc., and any affiliated employer of Walmart Stores, Inc. that participates in the Plan will be covered by this program. For the purposes of this Plan, these companies are individually and collectively referred to as "Employer." A list of employers participating in this Plan is attached to the back of this booklet as Appendix B.

How does the Plan affect me?

If you are injured on the job, the Employer will provide you with many benefits under the Plan, including paying for your covered medical care and making sure you receive a paycheck if you need to stay at home to recover. The Employer pays the entire cost of the Plan.

Do I have to do anything to enroll in the Plan?

No. If you are a Texas Associate of an Employer, you are automatically covered under this Plan. You do not need to enroll.

What are the advantages of the Plan?

We expect the Plan to better fit your needs in several ways, including:

- *Access to quality physicians who are not available in the Texas Workers' Compensation System*
- *Faster handling of your injury benefit claims*

- *Faster payment of your injury benefit claims*
- *More personalized attention to you if you are hurt on the job*
- *Payment of wage replacement benefits through regular payroll processes, including continuation of most benefit deductions*

Is there a waiting period before my wage replacement benefits will begin?

No. Instead of the seven-day waiting period that is required by Texas Workers' Compensation, the Plan starts replacing your wages with a paycheck from the first full day that you miss work.

What are some of the requirements of the Plan?

All accidents and injuries will need to be reported immediately – no later than 24 hours from the time of the injury. ***Immediate reporting is required so we can ensure you receive prompt medical care and so we can investigate and correct any avoidable hazards.*** A culture of safety requires immediate attention to work-related injuries.

To receive Plan benefits, you may only use physicians, hospitals and clinics that have been approved by the Claims Administrator. These approved physicians and approved facilities have been chosen for their ability to provide occupational injury medical services. *If you are not satisfied with the decision or diagnosis by an approved physician, you can get a second medical opinion from another physician (as described later in this booklet).*

How are benefit payments handled?

Plan benefit decisions will be made, and any concerns that you have will be addressed, directly by the Employer and its designated adjusters. You will find this to be a much easier and faster process than working through the state. We expect to provide a better service when addressing the needs of our injured associates.

What if I am not satisfied with how my benefit claim is handled?

You have the opportunity to file an appeal with an Appeals Committee. On appeal, the Appeals Committee will conduct an independent review of the claim and you may submit additional information supporting payment of the claim.

What if I have other issues related to my injury?

This program includes arbitration procedures to resolve other injury-related disputes between you and the Employer quickly and fairly. Arbitration is a process in which a skilled, independent arbitrator (similar to a judge) hears both sides of the situation and then makes a final and binding decision. A detailed description of the arbitration procedures is outlined in Appendix A to the Summary Plan Description.

What are the advantages of arbitration?

Protected Rights

Arbitration offers the same fundamental protections as a court of law. And the arbitrator, just like a judge or jury, may award you anything you might seek through a court of law.

Fast Decisions

When a problem is taken to court, it often takes years to conclude. With arbitration, hearings can often be scheduled within a month or so of your request and decisions can be reached in just a few months.

Fair Decisions

Courts hear all types of cases ranging from car accidents to divorces. Judges and juries do not specialize in solving work-related problems. But arbitrators do. More importantly, the arbitrator is objective and does not have any relationship with the Employer.

Does this Plan directly affect my health insurance or other benefits?

No. This Plan is a separate program from your health insurance and other benefits and applies only when injuries happen on the job.

When does this Plan take effect?

It is effective for all on-the-job injuries involving Texas associates that occur on or after March 1, 2012.

PLAN BENEFITS

Maximum Benefit Limit

Maximum amount for all benefits combined payable to you for an injury	\$300,000 per associate \$1,000,000 per occurrence
---	---

Medical Benefits

Pays for care from approved health care providers if you are Injured at work	100% of covered charges for up to 120 weeks
--	---

Wage Replacement Benefits

Pays you income if you need time away from work to recover	Starting on the first full day of disability pays 90% of your "lost wages" for Up to 120 weeks
--	---

Death Benefits

Provides payment to eligible beneficiaries if death occurs on the job	\$250,000 (paid 20% down and remainder over 35 months)
---	---

Burial Benefit

Provides reimbursement for burial expenses	Up to \$12,000
--	-----------------------

Dismemberment Benefits

Provides a payment for loss or loss of use of a member of the body	Up to \$250,000 , based upon the severity of the injury (paid 20% down and remainder over 35 months)
--	---

Please see the Program Detail section of this booklet for a more complete description of benefits, taxation issues, applicable exclusions, and limitations and requirements you must satisfy in order to receive benefits.

Case Study

How does the Plan work?

Take a look at the example below to see how the Plan's benefits might work if you have an injury.

Pat, who works in shipping, suffers a back injury. Pat, who earns \$500 a week, is not able to return to work until three weeks after the accident. Pat's total covered medical charges following the accident are \$3,000.

The Bottom Line

In this example, Pat would be eligible to receive **\$4,350** in benefits under the Plan.

Pat would receive:

- \$3,000 in Medical Benefits (100% of all covered medical charges)
- \$1,350 in Wage Replacement Benefits (90% of lost wages for the three weeks of disability)

*Of course, **Pat's case is just an example** and might not be like your situation at all if you're injured on the job. You may be entitled to receive more or less benefits than those provided in this example, depending on the severity of your injury and other factors.*

Reporting an Injury

What should I do if I am injured on the job?

We have set up procedures to make sure you receive treatment for your injuries in an efficient, quick manner. By following these and other Plan rules, your covered medical bills will be paid and your paycheck will continue even if you need to stay at home to recover. More detailed information on these procedures is found later in this booklet.

1. Report Your Injury Immediately

You must report your injury to your supervisor within 24 hours of the time of the injury. Don't wait! Your injury might get worse and we want to help you.

2. Fill Out an Incident Report

You must complete a report that provides details of the incident that resulted in your injury within 24 hours after the injury is reported. You and the Employer will then work together to investigate your claim.

3. Use an Approved Physician or Approved Facility for Medical Treatment

In order to receive injury benefits, you must use physicians, hospitals, clinics and other health care providers and facilities that have been approved by the Plan's Claims Administrator. You must also receive your first medical treatment from an Approved Physician or Approved Facility within 14 days after the date of your injury.

4. Submit to a Drug and/or Alcohol Screen

If you are injured on the job, you will be required to submit to a drug and/or alcohol test, in accordance with the Employer's substance abuse policy.

5. Follow the Doctor's Orders

You must follow the approved physician's instructions and keep all scheduled appointments with health care providers.

6. Welcome Back!

You must keep the Employer informed about your return to work status. We will look forward to welcoming you back as soon as the treating physician issues a medical release saying you are able to return to full or Temporary Alternative Duty.

PROGRAM DETAIL

INTRODUCTION

Walmart Stores, Inc. (the "Company") is committed to providing loss of income protection and helping you pay medical expenses if you are injured on the job. To accomplish this, the Company has implemented a benefit program called the Walmart Stores, Inc. Texas Injury Care Benefit Plan (the "Plan"). **The Plan has been adopted for the benefit of the Texas associates of Walmart Stores, Inc., Sam's East, Inc., Walmart Associates, Inc., and any affiliated employer of Walmart Stores, Inc. that participates in this Plan (individually and collectively referred to as the "Employer").** A list of employers participating in this Plan is attached to the back of this booklet as Appendix B. This booklet has been prepared to help you understand your benefits under the Plan. Please read it carefully.

This document and other descriptive material provided to you by your Employer are written in a manner that is intended to be easily understandable and to summarize the benefits available to you under this Plan. There may be other documents, such as the Official Plan Document, that contain more detailed information about the Plan benefits. Every effort has been made to ensure that all of these materials contain a consistent description of the benefits. However, if any conflict arises between the information contained in this booklet and the provisions of the formal Plan Document, the Plan Document will control. Certain terms used in this booklet are capitalized and defined in the DEFINITIONS section of this booklet.

Except as otherwise provided in this booklet, benefits and other requirements described in this booklet are effective for all covered injuries occurring on or after March 1, 2012.

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

The following notice is being provided as required by Texas law:

COVERAGE: Walmart Stores, Inc., Walmart Stores, Texas, LLC, Walmart Associates, Inc., Sam's East, Inc., Walmart Realty Company, Claims Management, Inc., Walmart.com, Inc. and Walmart Transportation, LLC have elected not to obtain workers' compensation insurance coverage. As an employee of a non-covered employer, you are not eligible to receive workers' compensation benefits under the Texas Workers' Compensation Act. However, a non-covered employer can and may provide other benefits to injured employees. You should contact your employer regarding the availability of other benefits or compensation for a work-related injury or illness. In addition, you may have rights under the common law of Texas should you suffer an on the job

injury or illness. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

SAFETY HOTLINE: The Division has established a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact Workers' Health & Safety at 1-800-452-9595.

This notice also applies to all Employers participating in the Plan.

Your Injury Benefit Plan: Your Employer **DOES PROVIDE** to all Texas associates, without cost, the benefits described in this booklet.

Our Safety Program: Our success largely depends upon you following all of our safety rules and procedures and immediately notifying your supervisor first of any unsafe working condition, safety violation or on-the-job injury, no matter how minor. As mentioned above, you will not be suspended, terminated, or discriminated against because you in good faith report an unsafe working condition, on-the-job injury or potential occupational health or safety violation.

ELIGIBILITY

You automatically become a participant in the Plan if you are an associate of the Employer and your employment with the Employer is principally located within the State of Texas. For driver associates, "covered associate" means an associate who is dispatched out of a distribution center located in the State of Texas. You must be a person who is employed in the regular business of, and receive your pay by means of a salary, wage or commission directly from, the Employer and for whom the Employer files a Form W-2 with the Internal Revenue Service. This Plan does not cover an independent contractor or third-party agent.

HOW THE PLAN WORKS

Procedure In Event Of Injury

- You must notify your supervisor immediately after being injured at work, no matter how minor the injury appears to be (including any disease exposure). For an Injury due to an Accident or for a known exposure to an Occupational Disease, verbal notice must be provided within 24 hours of the time of the Injury. For an actual Injury due to Occupational Disease or Cumulative Trauma, verbal notice must be provided 24 hours after being medically diagnosed with a work-related Injury, or within 30 days after you should have known of the work-

related Injury, whichever is earlier. You must also submit a written report to your supervisor within 24 hours after the Injury is reported.

- **For purposes of an Injury that involves an Accident, the date of the Injury shall be the date of the Accident resulting in the Injury.** For purposes of an Injury that involves an Occupational Disease or Cumulative Trauma, the date of the Injury shall be the earlier of (1) the date that the damage, harm or symptoms of the Occupational Disease or Cumulative Trauma were first known (or should have been known) to you, or (2) the date that an Approved Physician medically diagnosed you with an Occupational Disease or Cumulative Trauma.
- **You must receive medical care from an Approved Physician or Approved Facility.** You may use a non-approved physician or facility (and still be eligible to receive benefits under this Plan) only if the following requirements are satisfied:
 - **First**, the treatment must be for Emergency Care (as described further in the MEDICAL BENEFITS section of this booklet);
 - **Second**, you provide notice to the Claims Administrator of such Emergency Care within the later of 24 hours after your receipt of such care or the next business day; and
 - **Third**, after receiving primary treatment in Emergency Care, subsequent treatments must be provided by, or at the direction of, an Approved Physician or Approved Facility.
- **You must receive your first medical treatment from an Approved Physician or Approved Facility within 14 days after the date of your Injury.** If necessary, the Claims Administrator will assist you in arranging for appropriate treatment.
- **You must submit to alcohol and/or drug testing, in accordance with the Employer's substance abuse policy at the time of your initial medical treatment.** You must either provide the Employer with this alcohol and drug testing information or authorize the Employer to gain access to this information.
- **You must obtain pre-approval for all medical care from the Plan's Claims Administrator.** You do not have the right to select and have the Plan pay for your choice of a primary care provider or provider of specialty medical care, even if such provider is an Approved Physician or Approved Facility.
- **You must also follow the procedures described below in the REQUESTING BENEFITS section and comply with the requirements of the CONTINUING BENEFITS section of this booklet.**

Medical Determinations and Treatment

- As explained further below, in order to receive any benefits under this Plan, all medical care must be **pre-approved by the Claims Administrator** and furnished by

or under the direction of an **Approved Physician or Approved Facility (acting within the scope of their license)**, unless provided in connection with Emergency Care as described below.

- Any list of Approved Physicians and Approved Facilities will be furnished to you, without charge, as a separate document. The Claims Administrator reserves the right to add to, delete from, or otherwise amend any list of Approved Physicians or Approved Facilities at any time. **No Approved Physician or Approved Facility is an agent of the Employer. Although benefits under this Plan are conditioned on your use of only Approved Physicians and Approved Facilities, you remain entitled to seek any medical care you deem appropriate from any provider of your choice at your own expense. In addition, the Plan is not intended to affect your relationship with your health care providers. The actual medical treatment or rehabilitation of any Injury remains the sole prerogative and responsibility of you and your attending Approved Physician and other health care providers based on their independent judgment for the provision of health care.**
- For purposes of this Plan, all determinations relating to your physical condition and the payment of benefits (for example, inability to return to work or results of a prior Injury) must be made by an Approved Physician. You must follow fully and completely the advice of, and the course of medical treatment prescribed by, the treating Approved Physician, and must keep all scheduled appointments to fulfill the prescribed medical treatment plan. The Claims Administrator will have the right to require you to be examined or reexamined by an Approved Physician as often as they determine to be reasonably necessary or appropriate while you are receiving or claiming benefits under the Plan.

Funding

The Employer pays the entire cost to provide your coverage under this Plan and pays Plan benefits solely out of the general assets of the Employer. The Employer has the right, but no obligation, to obtain insurance contracts to provide funds to the Employer that can be used by the Employer to pay all or any portion of a benefit under the Plan; but no benefits under the Plan are guaranteed under any contract or policy of insurance and the Employer will be solely responsible for the payment of claims under this Plan. If the Employer has purchased an insurance policy, the purpose of which (in whole or in part) is to provide funds to the Employer for Plan benefits or that may be used to reimburse the Employer for Plan benefits, then:

- **benefit payments under this Plan shall not be payable or shall immediately cease in the event that benefits coverage is not available to the Employer or ceases under such policy for any reason; and**
- no such insurance policy proceeds shall be considered "plan assets" for purposes of ERISA. Policy proceeds shall constitute a part of the general assets of the Employer. Any such insurance policy shall be owned by, and all amounts under the

policy shall be payable to the Employer, and you shall not have any interest in, or right to, any amounts payable under the policy (even though certain benefit payment, reporting or other requirements of this Plan may relate to requirements of such insurance policy).

COVERED AND NON-COVERED INJURIES

Covered Injuries

The Plan pays benefits only on account of an **"Injury."** An "Injury" means damage or harm to the physical structure of the body resulting from either:

- an **"Accident"** (which means an event involving factors external to you that --
 - was unforeseen, unplanned, and unexpected;
 - occurred at a specifically identifiable time and place;
 - occurred by chance or from unknown causes; and
 - resulted in physical injury (or mental or emotional injury, in the event of a Violent Crime) to you);
- an **"Occupational Disease"** (which means a condition marked by a pronounced deviation from your normal healthy state arising out of your assigned duties in your Course and Scope of Employment. Occupational Disease includes other diseases or infections that naturally result from the work-related disease. Occupational Disease does not include ordinary diseases of life to which the general public is exposed outside of your assigned duties in your Course and Scope of Employment); or
- **"Cumulative Trauma"** (which means damage to the physical structure of your body occurring as a result of rapid, repetitious, physically traumatic activities that occur in the Course and Scope of Employment. The term "Cumulative Trauma" does not mean fatigue, soreness or general aches and pain that may have been caused, aggravated, exacerbated or accelerated by your Course and Scope of Employment. No benefits will be payable with respect to Cumulative Trauma unless you have completed at least 180 days of continuous, active employment with the Employer and have been regularly engaged in the Course and Scope of Employment with the Employer involving rapid, repetitious, physically traumatic activities).

Any such damage or harm must occur or arise during, and directly and solely result from, the Course and Scope of Employment by the Employer (see the DEFINITIONS section of this booklet). In order to be subject to the provisions of this booklet, **the date of the Injury must be on or after March 1, 2012.**

All injuries relating to (1) an Accident or related series of Accidents, (2) exposure to an environmental or physical hazard that causes Occupational Disease, or (3) rapid, repetitious, physically traumatic activities that result in Cumulative Trauma, will be considered a single Injury.

Types of Non-Covered Injuries

The term "Injury," as used in this booklet, does not include:

- Any strain, degeneration, damage or harm to, or disease or condition of, the eye or musculoskeletal structure, or other body part resulting from:
 - use of a video display terminal or keyboard;
 - poor or inappropriate posture;
 - the natural results of aging;
 - osteoarthritis, arthritis, or degenerative process (including, but not limited to, degenerative joint disease, degenerative disc disease, degenerative spondylosis/spondylolisthesis and spinal stenosis); or
 - other circumstances prescribed by the Claims Administrator which do not directly and solely result from your Course and Scope of Employment;
- Factors to which the general public is exposed;
- Diagnostic labels which imply generalized musculoskeletal aches and pains in the absence of any demonstrable primary pathophysiology, such as Fibrositis, Fibromyalgia, Myofascial Pain Syndrome, Myositis, or Chronic Fatigue Syndrome;
- Except to the limited extent provided under the section of this booklet entitled "Medical Services and Supplies Requiring Specific Approval in Writing or by Electronic Notice," any mental injury, emotional distress, mental trauma or similar injury to your mental or emotional state, including, without limitation:
 - any physical manifestations resulting from such mental or emotional state; and
 - any mental or emotional damage or harm that arises primarily from a personnel action, including, but not limited to, a transfer, promotion, demotion or termination of employment or other disciplinary action;
- Damage or harm resulting from airborne contaminants not commonly found in the Employer's normal working environment, including, but not limited to, pollen, fungi, and mold;
- Damage or harm resulting from job stress;
- Any heart attack, stroke, or aneurysm (an "attack"), unless --
 - the attack can be identified as --
 - occurring at a definite time and place; and

- caused by a specific event related to and occurring in the Course and Scope of Employment;
- the preponderance of the medical evidence regarding the attack indicates that your work rather than the natural progression of a preexisting heart condition or disease was a substantial contributing factor of the attack; and
- the attack was not triggered solely by emotional or mental stress factors, unless it was precipitated by a sudden work-related stimulus;
- Hernia, unless inguinal and/or umbilical hernia that -
 - appeared suddenly and immediately following the Injury;
 - did not exist in any degree prior to the Injury; and
 - was accompanied by pain; or
- Any Preexisting Condition, except to the limited extent (if any) that an Approved Physician clearly confirms an identifiable and significant aggravation (Incurred in the Course and Scope of Employment) of a Preexisting Condition; provided, however, that
 - coverage for such aggravation will be provided only if and to the extent that the Approved Physician –
 - confirms that the Preexisting Condition has been previously repaired or rehabilitated; and
 - prescribes services or supplies that are medically necessary to treat such aggravation and likely to return you to pre-Injury status; and
 - no coverage will be provided if the Preexisting Condition was a major contributing cause of the Injury.

Non-Covered Injury Circumstances

No benefits will be payable under the Plan if:

- you are not an associate of the Employer or your employment is not principally located in the State of Texas;
- the Injury occurred while you were in a state of intoxication or had otherwise lost the normal use of your mental or physical faculties as a result of the use of a drug or alcohol. For this purpose, you will be considered to have been in a state of intoxication at the time of the Injury if the drug or alcohol test required by the Employer finds a violation of the Employer's substance abuse policy;

- the Injury is treatable by medical care that is reasonable and of a form that an ordinary prudent person in the same or similar circumstances would undergo, and you have not availed yourself of such treatment;
- the Injury was caused by your willful intention or attempt to injure yourself or another person, whether you were sane or insane;
- the Injury occurred while you were employed in violation of any law;
- your horseplay, scuffling, fighting, or similar inappropriate behavior was a proximate cause of the Injury;
- your long-term cell phone use, or second-hand smoke was a proximate cause of the Injury;
- the Injury was incurred while you were "on suspension," "laid off" by the Employer, on leave of absence for any other reason, or otherwise outside of the Course and Scope of Employment;
- the Injury arose out of an act of a third person intended to injure you because of personal reasons and not directed at you as an associate or because of your employment;
- the Injury arose out of your participation in an off-duty recreational, social, charity, or athletic activity not constituting part of your work-related duties, except where these activities are expressly required in writing by the Employer (more than an invitation or request to participate or attend);
- the Injury arose out of an act of God, unless your employment exposes you to a greater risk of Injury from an act of God than ordinarily applies to the general public;
- the alleged Injury is feigned or an attempt to defraud the Employer;
- the Injury arose out of your participation in:
 - a riot or act of civil disturbance;
 - a war, declared or undeclared;
 - any act of war or terrorism;
 - any illegal act;
 - a felony or an assault, except an assault committed in defense of the Employer's business or property; or
 - service in the military of any country or any civilian non-combatant unit serving with such forces;
- any damage or harm arising out of the use of or caused by --
 - asbestos, asbestos fibers or asbestos products; or
 - the hazardous properties of nuclear material or biological contaminants;

- the Injury arose out of your participation in the commission, or attempted commission, of any crime;
- the Injury did not occur during your Course and Scope of Employment; or
- the Injury was not timely reported (or requested information was not timely provided) in accordance with the timeframes specified in the REQUESTING BENEFITS section of this booklet.

REQUESTING BENEFITS

The following is a summary of the procedures for requesting benefits under this Plan. Also see the section called DETAILED CLAIM PROCEDURES in this booklet.

Notice of Injury

You (or your Representative) must provide verbal notice of an Injury **immediately** to your supervisor then on duty.

- **For an Injury due to an Accident, or known exposure to an Occupational Disease, this verbal notice must be provided within 24 hours of the time of the Injury.**
- **For an actual Injury due to Occupational Disease or Cumulative Trauma, this verbal notice must be provided by the earlier of the following: (1) within 24 hours after being medically diagnosed with a work-related Injury, or (2) within 30 days after you should have known of the work-related Injury.**

Providing Required Information

You (or your Representative) must complete the incident report form and medical authorization form **within 24 hours after the Injury is reported**. These forms must be submitted to your supervisor (or such other person as the Claims Administrator may specify). You must provide verbal, written, or recorded statements, and provide such proof and demonstrations (relating to the Injury or any prior or subsequent damage or harm you suffered, in or out of the Course and Scope of Employment), in such manner and within such periods, as the Claims Administrator may direct from time-to-time.

An immediate incident report to your supervisor is essential so that the Claims Administrator can promptly verify the facts regarding your Injury and pay appropriate benefits. No benefits will be payable under the Plan if:

- **notice of Injury** is not provided as specified above, unless the Claims Administrator determines that good cause exists for failure to give notice in a timely manner; or
- **all required information** is not provided as specified above, unless the Claims Administrator determines that good cause exists for failure to provide such information in a timely manner.

MEDICAL BENEFITS

Subject to the medical management and other provisions of this Plan, medical services and supplies that are approved by the Claims Administrator (referred to below as "Covered Charges") are covered at 100%, with no co-pays, deductibles or other out-of-pocket expense to you, provided that all applicable Plan requirements are satisfied. The service or supply must be medically necessary, based on the nature of the Injury, as and when provided, and (1) cure or relieve the effects naturally resulting from the Injury; (2) promote recovery; or (3) otherwise enhance your ability to return to or retain employment. Such services and supplies are also subject to the other medical management provisions of the Plan. Coverage also requires satisfaction of the following requirements:

First and Continuing Treatment

- The first Covered Charge must be received from an Approved Physician and incurred within 14 days following the date of your Injury (unless the Claims Administrator determines that good cause exists); and
- No further amount shall be considered a Covered Charge if you do not receive medical treatment from an Approved Physician or Approved Facility (or scheduled treatment with an Approved Physician or Approved Facility has not been approved by the Claims Administrator) for a period of more than 60 days. This section does not apply to any Covered Charge for testing and any follow up vaccination for an Injury that involves a potential occupational exposure to a bloodborne pathogen.

Approved Provider and Pre-Authorization Requirements

The cost of a service or supply shall be a Covered Charge only if:

- Treatment is (1) furnished by or under the direction of an Approved Physician or Approved Facility, acting within the scope of the Approved Physician's or Approved Facility's license, and (2) pre-approved in accordance with the "Medical Provider Referrals" section of this booklet by the Claims Administrator (except when the Claims Administrator determines that prior approval was impossible under the circumstances). Such pre-approval may include authorization for multiple visits to an Approved Physician or Approved Facility; or
- Treatment is provided as Emergency Care and (1) the Claims Administrator receives notification of such Emergency Care within the later of 24 hours of your receipt of such care or the next business day; and (2) after receiving primary Emergency Care, subsequent treatments are provided by, or at the direction of, an Approved Physician or Approved Facility in accordance with the paragraph above.

An Emergency Care determination solely relates to consideration of an exception to the Plan's approved medical provider requirements. "Urgent

Care Claims" (as discussed in this booklet's claims procedures) may not arise to the level of involving Emergency Care. Any decision by you to seek treatment from an urgent care clinic or hospital emergency room does not necessarily involve Emergency Care. An Emergency Care determination shall be made within the sole administrative discretion of the Claims Administrator or Appeals Committee, with such advice and consultation from an Approved Physician as the Claims Administrator or Appeals Committee deems appropriate. If you obtain treatment from a non-approved health care provider and the Claims Administrator or Appeals Committee determines that your situation has not satisfied all of the above requirements, your claim for benefits will be denied.

Covered Medical Services and Supplies

Medical Services and Supplies. Subject to the restrictions and limitations set out elsewhere in this booklet, Covered Charges will include the cost of the following:

- Approved Physician visits - at an Approved Facility (including charges for an emergency room), Approved Physician's office, or in the case of home health care, at your home, including second opinion services requested by the Claims Administrator, and charges for a registered nurse;
- Medical supplies approved by the treating Approved Physician, including the following:
 - Prescription drugs (generic, unless trade name drugs are requested by an Approved Physician) and over-the-counter drugs such as analgesics prescribed by an Approved Physician;
 - Blood and other fluids (other than allergy, insulin, and similar drugs) injected into the circulatory system (but only to the extent not available through any refund or allowance by a blood bank or similar organization);
 - Oxygen and its administration;
 - Upon the written advice or prescription of an Approved Physician and only if obtained from an Approved Facility, rental or purchase of a wheelchair, assisted breathing apparatus, or other mechanical equipment necessary for the treatment of respiratory paralysis, and similar internal or external durable medical equipment designed primarily for therapeutic purposes;
 - Surgical dressings, bandages, splints, casts, crutches, syringes, needles, trusses, and braces dispensed by an Approved Physician or Approved Facility; and
 - Other items approved by the Claims Administrator;

If the authorized prescription or medical supply is available at a Walmart or Sam's Club location that is convenient to you, Walmart or Sam's Club is the exclusive Approved Facility.

- Ambulance services - professional ground ambulance service, or if no other means of transportation can reasonably suffice to deliver the individual to the closest appropriate Approved Facility, air ambulance, regularly scheduled railroad, or airlines;
- Eyeglasses or contact lenses – one pair per Injury up to \$400, inclusive of professional office visit charges, but excluding routine eye examinations. If the eyeglasses or contact lenses are available at a Walmart or Sam's Club location that is convenient to you, Walmart or Sam's Club is the exclusive Approved Facility;
- External hearing aid - up to \$600 per ear, inclusive of professional office visit charges;
- Admission to an Approved Facility on an inpatient or outpatient basis, including semi-private room and board, ambulatory day surgery, anesthesia and its administration, and similar services;
- Diagnostic testing, including x-ray examinations, laboratory tests, MRI, CAT Scan, nuclear medicine, radiology and pathology (including interpretive services) and similar testing;
- Speech, occupational and physical therapy provided by an Approved Physician or a licensed speech therapist, licensed occupational therapist or licensed physical therapist; provided, however, that such services shall be subject to case management approval regarding the number of visits, the types, and amount of services provided during such visits;
- Inpatient rehabilitation services provided in a medical rehabilitation hospital; provided, however, that such services shall be subject to continued stay review by the Claims Administrator and case management approval regarding the types and amount of services provided;
- Limited or temporary pain management services (for example, epidural steroid injections), but not including pain management programs;
- Surgery that restores a reasonable, normal pre-Injury functioning;
- Services of a dentist or licensed oral surgeons - services for treatment and repair of broken teeth, fractures and dislocations of the jaw, or the replacement of teeth (excluding temporomandibular junction dysfunction services) when you seek treatment as soon as possible after the Injury;
- Home health care (with respect to physical needs only) up to 75 visits per Plan Year and up to eight hours per visit for the first two weeks of home health care and up to four hours per visit thereafter;
- Skilled nursing care, provided that an Approved Physician monitors your progress at least once during each 30-day period of confinement;

- Orthotics, arch supports, corrective shoes, special bras or girdles, corrective appliances, prosthesis, or any similar item;
- Organ and tissue transplant services not otherwise covered by some form of expense payment program, excluding the donor's transportation costs, organ procurement costs and the donor's surgical expenses;
- Charges for telephone consultations with you, your Representative, Approved Physicians or other health care providers;
- Mental health services (to the extent not otherwise covered by the Employer's Employee Assistance Program), but only when such services are provided for mental or emotional damage or harm resulting from you being the victim of, or witness to, a Violent Crime occurring during your Course and Scope of Employment. This coverage will apply solely to Medical Benefits coverage and will not result in any payment of Wage Replacement Benefits or other benefits under this Plan;
- Services rendered primarily for training, testing, evaluation, counseling, or educational purposes; and
- Reasonable travel, meal and lodging expenses related to medical treatment that requires travel greater than 50 miles from your residence (one way) as interpreted by the Claims Administrator for application under this Plan and approved by the attending Approved Physician. Mileage will be reimbursed at the Internal Revenue Service identified "Medical Purposes" rate, as periodically updated.

Non-Covered Medical Services and Supplies

While the Plan provides benefits for many medical expenses, the following expenses are **not** covered by the Plan:

- Charges incurred prior to your date of participation in the Plan, or prior to your date of Injury;
- Charges rendered after your Medical Benefits under this Plan terminate;
- Expenses which are not medically necessary, as determined by the Claims Administrator;
- Charges incurred more than 60 days after the date of the last Covered Charge (except as otherwise specified in this booklet);
- Expenses that exceed any fee schedule adopted by the Claims Administrator or the usual and customary charge for the same or similar treatment, services or supplies in your geographic area;
- Services or supplies payable by any government or subdivision or agency thereof, or any other applicable third-party payor;

- Services or supplies which are experimental, investigative, or for the purposes of research, including, but not limited to, services and supplies that have not been approved by the American Medical Association, the Food and Drug Administration, the appropriate medical specialty society, or the appropriate governmental agency, all phases of clinical trials, all treatment protocols based upon or similar to those used in clinical trials, or any treatment not generally accepted by the physician's profession in the United States as safe and effective for diagnosis and treatment;
- Services or supplies performed or provided while you are not covered by the Plan;
- Services or supplies for which you are not legally obligated to pay or for which no charge would be made in the absence of the Plan;
- Services for the evaluation or treatment of mental or psychological damage or harm, except to the extent provided above;
- Services or supplies for personal comfort or convenience, such as a private room, television, telephone, radio, guest trays, and similar items;
- Fraudulent claims or claims not filed in good faith as determined by the Claims Administrator;
- Canceled appointment charges;
- Self-administered services;
- Services or supplies to which your condition is persistently nonresponsive;
- Services or supplies relating to Preexisting Conditions, except to the limited extent (if any) that an Approved Physician clearly confirms an identifiable and significant aggravation (incurred in the Course and Scope of Employment) of a Preexisting Condition; provided, however, that --
 - coverage for such aggravation will be provided only if and to the extent that the Approved Physician -
 - confirms that the Preexisting Condition has been previously repaired or rehabilitated, and
 - prescribes services or supplies that are medically necessary to treat such aggravation and likely to return you to pre-Injury status; and
 - no coverage will be provided if the Preexisting Condition was a major contributing cause of the Injury;
- Acupuncture, behavior modification, pain management programs, hypnosis, biofeedback, other forms of self-care or self-help training or any related diagnostic testing, or any service or supply ancillary to any of these treatments;

- Chiropractic or spinal manipulation services;
- Substance abuse services;
- Services and supplies provided in or out of a rest home, convalescent facility, nursing home, or other institution that only assist with activities of daily living such as bathing, dressing, walking, eating, preparing special diets, or the supervision of taking medications, no matter by whom recommended or furnished;
- Charges for the purchase, rental or repair of bedding, or environmental control devices, including, but not limited to, an air conditioner, humidifier, dehumidifier, or air purifier, and charges for jacuzzis, saunas, vans, or structural changes to your residence or moving expenses;
- Charges for services performed by:
 - a person who normally lives with you;
 - your spouse;
 - a parent of you or your spouse;
 - a child of you or your spouse; or
 - a brother or sister of you or your spouse; and
- The cost of any other service or supply not specified above as a Covered Charge.

Initial Treatment and Denial

The Employer may render first aid, or the Plan may pay for Emergency Care, pay Wage Replacement Benefits or pay for a medical evaluation or treatment, and the Plan can still make a subsequent determination that you have not suffered a covered Injury or can deny any or all further benefits under the provisions of this Plan.

Medical Provider Referrals

If the treating Approved Physician finds it necessary to refer you to another health care provider, the treating Approved Physician must notify you and the Claims Administrator of his or her desire to make the referral and the objectives of such referral. The Claims Administrator will provide advance approval or disapproval of all referrals (and may rescind any such approval at any time) based upon such criteria as the Claims Administrator may determine for the effective administration of the Plan. **It is your responsibility to determine the status of any such approval or disapproval, and the expense of services or supplies relating to any disapproved referral will be solely your responsibility.**

No Interference with Patient-Provider Relationship

Even though benefits under this Plan are conditioned on your use of only Approved Physicians and Approved Facilities, you remain entitled to seek any medical care that you deem appropriate from any provider of your choice at your own expense. **However,**

any medical expenses for this medical care will not be payable under this Plan and your use of a non-approved physician or facility may result in a complete denial or termination of benefits under this Plan. The Employer, Claims Administrator, Appeals Committee, and their agents and delegates, shall not have any responsibility for the actual medical or other health care services provided by any Approved Physician, Approved Facility or other designated health care service provider. Health care providers are not agents of the Plan, Employer, Claims Administrator, or Appeals Committee. The Plan, Employer, Claims Administrator, and Appeals Committee are not liable or responsible for the acts or omissions of any health care provider. The actual medical treatment or rehabilitation of any Injury remains the sole prerogative and responsibility of the attending Approved Physician and other health care providers based on their independent judgment for the provision of health care.

Second Medical Opinions

The Plan reserves the right to require a second medical opinion from an Approved Physician selected by the Claims Administrator for purposes of obtaining an Independent Medical Evaluation (IME) or for any other reason relating to the payment of Medical Benefits, Wage Replacement Benefits, or any other benefits under this Plan. If you refuse to be examined by an Approved Physician selected by the Claims Administrator for the second opinion, all benefits under the Plan will be suspended.

The Claims Administrator will weigh the findings of the treating Approved Physician and the Approved Physician providing the second opinion and make a benefit determination under the Plan. However, if you disagree with the diagnosis or treatment recommended by the Approved Physician whose opinion is accepted by the Claims Administrator ("Physician A"), then you may request a second medical opinion. **You must notify the Claims Administrator in advance of receiving any second medical opinion in order for this opinion to be considered by the Plan.** If you provide advance notice to the Claims Administrator, then you shall have the right to a one-time examination at your own expense by another physician ("Physician B"). This examination by Physician B will be solely for the purpose of evaluating your condition and making a treatment recommendation.

If the diagnosis and treatment recommended by Physician B is contrary to that of Physician A, then the Claims Administrator shall designate a peer review physician who will evaluate the medical records and advise the Claims Administrator, and who may designate another Approved Physician for a further medical examination. **If you refuse to be so examined, all benefits under the Plan may be suspended.** The diagnosis and/or recommended treatment of the peer review physician or this last Approved Physician will be controlling. The fees and related expenses of the peer review physician and this last Approved Physician will be paid by the Plan (although you will have the option of paying up to one-half of such fees and expenses).

When Medical Benefits Cease

Medical Benefits will cease upon the earliest of:

- the expiration of 120 weeks from the date of the Injury;
- reaching the Maximum Benefit Limit;
- involuntary termination of your employment with the Employer for gross misconduct;
- the date that you do not receive medical treatment from an Approved Physician or Approved Facility (or scheduled treatment with an Approved Physician or Approved Facility has not been approved by the Claims Administrator) for a period of more than 60 days; or
- your failure to comply with the requirements under the CONTINUING BENEFITS section of this booklet.

WAGE REPLACEMENT BENEFITS

When Wage Replacement Benefits Begin

- **Total Disability.** From the first full day that you become Totally Disabled due to a covered Injury, the Plan shall pay Wage Replacement Benefits equal to 90% of your Pre-Injury Pay.
- **Partial Disability.** From the first full day you become Partially Disabled, the Plan shall pay Wage Replacement Benefits equal to 90% of the portion of your Pre-Injury Pay that you are unable to earn (due to the Approved Physician's restrictions) while working Temporary Alternative Duty.
 - If you have a Partial Disability and are released to Temporary Alternative Duty, but (i) the Employer has no Temporary Alternative Duty position available, and (ii) an Approved Physician has not assigned permanent restrictions and released you to any other gainful employment, then you will be considered to be Totally Disabled and Wage Replacement Benefits shall be payable in the manner specified above under "Total Disability."
 - If you have a Partial Disability and have made a good faith effort to comply with the treating Approved Physician's instructions and carry out your responsibilities in the Temporary Alternative Duty position, but you are either:
 - again determined by an Approved Physician to be Totally Disabled, or
 - the Temporary Alternative Duty position ceases to be available (for example, the position reaches its maximum duration) and an Approved Physician has not assigned permanent restrictions and released you to any other gainful employment;

then you will be considered to be Totally Disabled and Wage Replacement Benefits shall be payable in the manner specified above under "Total Disability."

The Employer's ability to provide a Temporary Alternative Duty position while you are under work restrictions determined by the Approved Physician does not imply or create a permanent Temporary Alternative Duty position for the purposes of the American with Disabilities Act ("ADA").

➤ **Payment Terms and Other Limitations.**

- An Approved Physician must make the determination regarding whether you are Disabled, except to the extent that such determination is made in conjunction with Emergency Care as determined by the Claims Administrator.
- You cannot receive Wage Replacement Benefits if you are not receiving Medical Benefits from an Approved Provider.
- Wage Replacement Benefits are calculated on a weekly basis, and paid on regular paydays. Payments for portions of a week shall be prorated.
- Only your normal, scheduled workdays shall be considered in calculating benefits (based upon your employment status as of the date of Injury).
- Wage Replacement Benefit payments shall be reduced as described in the "Offset For Other Benefits" section of this booklet.

When Wage Replacement Benefits Cease

Wage Replacement Benefits will continue until the earliest of:

- the expiration of 120 weeks from the date of the Injury. This 120-week maximum period for Wage Replacement Benefits is calculated continuously from the date of the Injury, regardless of whether or not you qualify as Disabled at all times during such period or receive Wage Replacement Benefits continuously throughout such period;
- the date you are determined by the treating Approved Physician to no longer be Disabled. (It does not matter whether you return to regular or Temporary Alternative Duty on that date);
- the date that the Maximum Benefit Limit is met;
- termination of all your employment with the Employer. But, this paragraph will not apply if termination of employment is solely due to -
 - application of a duration limit in the Employer's leave of absence policy, or
 - elimination of your employment position;
- the date you are placed in jail, are deported or detained by or at the request of any

government agency or foreign government, have left the local area for an extended period of time, or are similarly unavailable for work. This paragraph shall operate to cease Wage Replacement Benefits only for such period of time that you are unavailable for work; or

➤ as otherwise provided under the CONTINUING BENEFITS section below.

Other Benefit Reductions

Wage Replacement Benefits are generally considered taxable income, and all appropriate amounts will be withheld. Also, amounts legally garnished may be withheld and appropriate Pre-Injury Pay deductions, like insurance premiums, will continue to be withheld unless you provide instructions to the contrary in accordance with applicable program rules and procedures.

DEATH BENEFITS

If you die as the direct and sole result of, and within 365 days of, an Injury, the Plan will pay your Beneficiary a Death Benefit equal to \$250,000. This benefit amount shall be reduced to the extent necessary to avoid exceeding the Plan's Maximum Benefit Limit.

The Death Benefit will be paid to your Beneficiary as follows: (1) 20% will be paid in a lump sum cash payment as soon as administratively possible following your death; and (2) the remainder will be paid in 35 equal monthly installments (without interest) commencing on the first day of the month following the initial lump sum payment. Death Benefits will be in addition to Dismemberment Benefits, Wage Replacement Benefits, and Medical Benefits payable with respect to any one Injury; but, no interest in future Dismemberment Benefits survives after your death if your Beneficiary then becomes entitled to Death Benefits under this Plan. In addition to the Death Benefits explained above, the Plan shall reimburse reasonable burial expenses to any person who incurs that liability, up to \$12,000. Reimbursed reasonable burial expenses are not subject to the Maximum Benefit Limit.

DISMEMBERMENT BENEFITS

If you suffer a loss described in the Schedule of Losses below as the direct and sole result of, and within 365 days of, an Injury, then the Plan will pay you an amount equal to the applicable percentage from the schedule below times \$250,000. This benefit amount shall be reduced to the extent necessary to avoid exceeding the Plan's Maximum Benefit Limit. For example, if you suffer an Injury resulting in the loss of the sight in one of your eyes (as described below), you would generally be entitled to a Dismemberment Benefit of \$125,000 (50% x \$250,000).

The Dismemberment Benefit will be paid as follows: (1) 20% will be paid in a lump sum cash payment as soon as administratively possible following the date of loss; and (2)

the remainder will be paid in 35 equal monthly installments (without interest) commencing on the first day of the month following the initial lump sum payment.

SCHEDULE OF LOSSES

<u>Loss of:</u>	<u>Benefit Amount:</u>
Both Hands	100%
Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
Speech and Hearing	100%
One Hand	50%
One Foot	50%
Sight of One Eye	50%
Speech	50%
Hearing	50%
Finger or Toe (two joints)	10%
Finger or Toe (one joint)	5%

- If you suffer more than one Injury described above from any one Accident, related series of Accidents, Occupational Disease exposure or Cumulative Trauma exposure, only one of the applicable Dismemberment Benefits listed above (the largest single amount) will be payable with respect to such Accident or exposure.
- Total and permanent loss of use of a member of the body is the same as loss of such member. Prior to payment of the benefit, loss of use must be certified following the care of an Approved Physician for 12 straight months from the date the loss of use began. At the end of this time it must be medically determined by an Approved Physician that the loss of use is total and not reversible.
- Loss of Hand or Foot means the complete and permanent severance through or above the wrist or ankle joint (or the total and permanent loss of use as described above). Loss of Sight means legally blind. Such loss correctable by surgery or lenses will not result in payment of a Dismemberment Benefit. Loss of Speech means the total and permanent loss of speech. Loss of Hearing means the total and permanent loss of hearing in both ears.
- The above-described loss of "Finger or Toe (two joints)" must be at or above the joint at the proximal end of the middle phalanx of the finger or toe; except that for the thumb or great toe, such loss must be at or above the metacarpophalangeal joint. The above-described loss of "Finger or Toe (one joint)" must be at or above the joint at the distal end of the middle phalanx of the finger or toe; except that for the thumb or great toe, such loss must be at or above the joint at the distal end of the proximal phalanx. (If you have any questions regarding a loss of "Finger or Toe (two joints)"

or a loss of "Finger or Toe (one joint)," you should consult an Approved Physician or contact the Claims Administrator.)

- Dismemberment Benefits will be in addition to Wage Replacement Benefits and Medical Benefits; provided, however, that payment of Dismemberment Benefits will cease in the event of death that results in the payment of Death Benefits.

CONTINUING BENEFITS

Subject to the limitations and other rules and procedures described in this booklet, your benefits under this Plan will begin or continue as long as you --

- submit to any requested drug and/or alcohol testing in accordance with the Employer's substance abuse policy, and provide the Employer with this alcohol and/or drug testing information or authorize the Employer to gain access to this information;
- receive prior approval for all medical care (except in the case of Emergency Care, as explained in the MEDICAL BENEFITS sections of this booklet);
- utilize only Approved Physicians and Approved Facilities (except in the case of Emergency Care, as explained in the MEDICAL BENEFITS sections of this booklet);
- submit to examination by an Approved Physician selected by the Claims Administrator (other than the treating Approved Physician) as required by the Claims Administrator with respect to any surgical procedure or other diagnosis or treatment opinion rendered by the treating Approved Physician for which the Claims Administrator considers a second medical opinion advisable;
- do not reach Maximum Rehabilitative Capacity;
- are responsive to treatment. Nonresponsiveness would include, but not be limited to, nonresponsiveness due to the need for participant behavioral modification recommended by the treating Approved Physician;
- provide accurate information to, and follow the directions of, a treating Approved Physician. Following the directions of a treating Approved Physician includes, but is not limited to, any recommended treatment, therapy, course of action, abstinence or rehabilitation program;
- allow an authorized representative of the Plan to go with you to appointments with health care providers;
- keep and be on time for all scheduled appointments with health care providers. Except in extraordinary circumstances as determined by the Claims Administrator, a first missed appointment will result in a warning and/or suspension of benefits and a second missed appointment will result in a termination of benefits;

- do not engage in conduct which hinders your recovery;
- actively participate in activities that increase the likelihood of your return to work or return to pre-injury status, including but not limited to reporting work status or work status or expected recovery time after each appointment as directed during the course of the claim;
- immediately inform your supervisor that you have been released by an Approved Physician to return to full or Temporary Alternative Duty, and timely report to work in accordance with such work release within 24 hours of such release;
- do not receive benefits with respect to the Injury from any workers' compensation law (regardless of whether or not any coverage for benefits is actually in force under such law);
- are truthful and do not demonstrate bad faith in connection with administration of the Plan, including, but not limited to, any aspect of the required information supplied as part of the Injury reporting or employment process;
- fully cooperate with the Claims Administrator (including, but not limited to, the requirements on providing information) in connection with the administration of the Plan, including, but not limited to, subrogation or coordination of benefits procedures; and
- comply with the provisions of this summary plan description, the Plan, and the rules and procedures adopted by the Claims Administrator for the administration of the Plan.

DETAILED CLAIM PROCEDURES

Filing a Claim for Benefits

A claim for Medical Benefits, Wage Replacement Benefits, or Dismemberment Benefits under the Plan will be initiated by you (or your Representative) by complying with the injury notice and medical treatment requirements found in the REQUESTING BENEFITS section and other parts of this booklet. A claim for Death Benefits under the Plan shall be initiated by a Beneficiary providing notice of entitlement thereto to the Claims Administrator within 90 days after the date of the participant's death. If, within two years after any amount becomes payable under this Plan to an individual, but the individual fails to claim such amount and the Claims Administrator has exercised reasonable diligence in attempting to make such payment, the amount shall be forfeited and shall cease to be a liability of this Plan.

- **What is a Claim** -- Each (1) medical service or supply for which payment is requested, (2) Wage Replacement Benefit for a particular payroll period, or (3) claim for Death Benefits or Dismemberment Benefits, will be deemed a separate "claim" for benefits that is subject to a determination under the Plan. The Plan's payment of

a particular claim (for example, payment for an initial medical evaluation, even on a claim that may have been reported late) does not waive or otherwise prejudice the Claims Administrator's or Appeals Committee's right to deny another particular claim or all future claims for benefits under the Plan. Any failure by the Claims Administrator or Appeals Committee to apply any provisions of this Plan to any particular situation shall not represent a waiver of the Claims Administrator's or Appeals Committee's authority to apply such provisions thereafter.

- **Who Is a Claimant** -- A claimant or a claimant's Representative may file a claim for benefits under the Plan, as well as an appeal of an Adverse Benefit Determination. References in this DETAILED CLAIMS PROCEDURES section to "claimant" may include you, a medical provider seeking payment for a service or supply, or a claimant's authorized Representative, as applicable.
- **Information to Submit** -- Claims must include the information required by the REQUESTING BENEFITS section above and such other reasonable information requested by the Claims Administrator, such as medical records or a written statement from an independent service provider evidencing the date, type of services rendered, and the total cost of such services. In addition, the Claims Administrator may require the claimant to provide a written and signed statement that provides that the amounts requested for payment under this Plan have not been reimbursed, or is not reimbursable under any other plan or program. Further, the Claims Administrator may also request that the claimant file all appropriate claims and requests for payment from any other plan or program maintained by the claimant prior to making any payments under this Plan. See the OFFSET, REIMBURSEMENT, AND RECOVERY OF BENEFITS section of this booklet.
- **Submission of Medical Bills for Payment** -- Approved Physicians and Approved Facilities will be requested to invoice all health care-related charges directly to the Claims Administrator (or the Employer, which will immediately transmit such invoice to the Claims Administrator). However, in the event that you receive such an invoice or pay such a charge, you must file all requests for payment or reimbursement of covered charges with the Claims Administrator within 30 days from the date such expenses are incurred or, if later, the date you receive an invoice from an Approved Physician, Approved Facility, or other health care provider (in the case of Emergency Care) for such expenses.
- **Incomplete Claim Submissions** -- If a claim, as originally submitted, is not complete, the Claims Administrator will notify the claimant in the manner described below, and the claimant will have the responsibility for providing the missing information. Subject to the applicable provisions of this DETAILED CLAIMS PROCEDURES, if the period of time for a particular claim is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination will be suspended from the date on which the notification of the extension is sent to the claimant until the date on which the Claims Administrator receives the claimant's response to the request for additional information.

Claims Review Procedures

- **Notice of Initial Benefit Determination** - The Claims Administrator will provide notice to the claimant of its initial benefit determination as follows:
 - **Urgent Care, Pre-Service Medical Claims** - In the case of an Urgent Care Claim for Medical Benefits, the Claims Administrator will notify the claimant of the Plan's initial benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies of the particular claim, but not later than 72 hours after receipt of the claim. However, if the claimant (1) fails to follow the Plan's procedures for filing an Urgent Care Claim, or (2) otherwise fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan on an Urgent Care Claim, then:
 - The Claims Administrator will notify the claimant as soon as possible, but not later than 24 hours after its receipt of the claim, of the procedure to follow or the specific information necessary to complete the claim. This notice requirement will only apply to the extent that such failure is a communication by a claimant that is received by the Claims Administrator, and the communication names a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.
 - The claimant will then be given a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to correct such failure.
 - The Claims Administrator will then notify the claimant of the Plan's initial benefit determination as soon as possible, but not later than 48 hours after the earlier of (i) the Claims Administrator's receipt of the specified information necessary to complete the claim, or (ii) the end of the time period given the claimant to provide such information.
 - **Concurrent Medical Care Decisions** - If the Claims Administrator has approved an ongoing course of medical treatment to be provided over a period of time or number of treatments:
 - The Claims Administrator will notify the claimant of any reduction or termination by the Plan of such course of treatment. Such reduction or termination will be considered an Adverse Benefit Determination and the Claims Administrator will notify the claimant sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a benefit determination on review before the course of treatment is actually reduced or terminated.
 - Any request by a claimant to extend the course of treatment beyond the prescribed period of time or number of treatments previously approved by the Plan that is an Urgent Care Claim will be decided as soon as possible, taking into account the medical exigencies of the claim. The Claims Administrator

will make an initial benefit determination, whether adverse or not, within 24 hours after its receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If such claim is not made to the Plan within such 24-hour period, the request will be treated as an Urgent Care Claim and be decided within the normal Urgent Care Claim timeframes (in other words, as soon as possible, taking into account the medical exigencies of the claim, but not later than 72 hours after receipt).

- Any request by a claimant to extend the course of treatment beyond the prescribed period of time or number of treatments previously approved by the Plan that is not an Urgent Care Claim will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (i.e., as a Pre-Service Claim or a Post-Service Claim).

Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving an Urgent Care Claim or not, will be made in accordance with the provisions of this section of the booklet.

- **Non-Urgent Care, Pre-Service Medical Claims** - In the case of a Pre-Service Claim for Medical Benefits that is not an Urgent Care Claim, the Claims Administrator will notify the claimant of the Plan's initial benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after its receipt of the claim.
 - If the claimant fails to follow the Plan's procedures for filing a non-urgent care, Pre-Service Claim, then the Claims Administrator will notify the claimant as soon as possible, but not later than 5 days after its receipt of the claim, of the procedure to follow. This notice requirement will only apply to the extent that such failure is a communication by a claimant that is received by the Claims Administrator, and the communication names a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.
 - The Claims Administrator may extend the 15-day benefit determination period up to an additional 15 days if it determines that, due to matters beyond the control of the Plan, an initial benefit determination cannot be made within the first 15-day period, and notifies the claimant of the special circumstances requiring the extension and the date by which the Plan expects to render a decision. If additional information is necessary to decide the claim, the extension notice shall specifically describe the required information and the claimant shall then be given at least 45 days to provide the specified information. However, the Claims Administrator's timeframe for making a benefit Determination shall be suspended until the date upon which the claimant responds to the request for additional information.

- **Post-Service Medical Benefit, Wage Replacement Benefit, Death Benefit, and Dismemberment Benefit Claims** - In the case of a Post-Service Claim for Medical Benefits or a claim for Wage Replacement Benefits, Death Benefits or Dismemberment Benefits, the Claims Administrator will notify the claimant of an Adverse Benefit Determination within 30 days after its receipt of the claim. The Claims Administrator may extend this period up to an additional 15 days if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan. Notice of such extension must be provided to the claimant prior to the expiration of the initial 30-day period and state (1) the special circumstances requiring the extension, and (2) the date by which the Plan expects to render a decision. If the extension relates to a claim for Wage Replacement Benefits, such notice will also state (1) the standards on which entitlement to benefits is based, and (2) unresolved issues that prevent a benefit determination on the claim and what additional information is needed to resolve those issues. If additional information is requested with the extension notice, the claimant will have 45 days from the date of the notice of extension to provide the specified information. However, the Claims Administrator's timeframe for making a benefit determination shall be suspended until the date upon which the claimant responds to the request for additional information.
- **Manner and Content of Adverse Benefit Determinations** - If the initial benefit determination is an Adverse Benefit Determination (that is, your claim for benefits is denied), the Claims Administrator will provide a written or electronic notice to the claimant that satisfies the following requirements:
 - Any electronic notice will satisfy ERISA regulations that specify the standards for electronic disclosure of benefit plan information;
 - The notice will be written in a manner calculated to be understood by the claimant;
 - The notice will set forth the specific reason or reasons for the Adverse Benefit Determination, making reference to the specific Plan provisions on which the Adverse Benefit Determination is based;
 - If an internal rule, guideline, protocol or other similar criterion was relied upon in making an Adverse Benefit Determination on a claim for Medical Benefits or Wage Replacement Benefits, the notice will state that such rule, guideline, protocol or other similar criterion was relied upon and that a copy thereof will be provided free of charge to the claimant upon request;
 - If the Adverse Benefit Determination of a Medical Benefits or Wage Replacement Benefits claim is based upon medical necessity, an experimental treatment or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the Adverse Benefit Determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

- The notice shall include a statement that In the case of an Adverse Benefit Determination on review by the Appeals Committee, the Plan offers no further voluntary levels of appeal and that the claimant can pursue his or her right to bring a legal action under ERISA section 502(a);
 - If the initial Adverse Benefit Determination involves an Urgent Care Claim, the notice will provide a description of the expedited review process applicable to such claims. Notification of an Adverse Benefit Determination that involves an Urgent Care Claim may be provided to the claimant orally within the time frames specified above, provided that the oral notification satisfies the requirements of this subsection and that a written or electronic notice satisfying the requirements of this subsection is furnished to the claimant not later than 3 days after the oral notification;
 - The notice will describe any additional materials or information necessary for the claimant to perfect the claim and explain why such material or information is necessary; and
 - The notice will provide a description of the Plan's review procedures (including the time limits applicable to these review procedures).
- **Appeal of Adverse Benefit Determinations** -- The claimant may appeal in writing an Adverse Benefit Determination to the Appeals Committee within the following number of days following his or her receipt of the Adverse Benefit Determination from the Claims Administrator:
- 180 days for a Medical Benefits or Wage Replacement Benefits claim; or
 - 60 days for a Death Benefit or Dismemberment Benefit claim.

If the Adverse Benefit Determination involves an Urgent Care Claim for Medical Benefits, the claimant may request orally or in writing an expedited review of the Adverse Benefit Determination and all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the claimant by telephone, facsimile or other available expeditious method.

- **Appeals Committee Consideration** -- When reviewing the appeal of an Adverse Benefit Determination, the Appeals Committee will comply with the following requirements:
- The claimant may submit written comments, documents, records, and other information relating to the claim for benefits, and the Appeals Committee will take all of such information into account when reviewing the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

- The claimant may receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information that is relevant to the claimant's claim for benefits (as determined by the Appeals Committee);
 - The Appeals Committee review of an Adverse Benefit Determination on a claim for Medical Benefits or Wage Replacement Benefits will not give any deference to the claimant's initial Adverse Benefit Determination.
 - If the appeal request on a Medical Benefits or Wage Replacement Benefits claim is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the Appeals Committee will consult with an Approved Physician who has appropriate training and experience in the field of medicine involved in the medical judgment. This Approved Physician will not be an individual who was consulted in connection with the initial Adverse Benefit Determination or a subordinate of such individual
 - Upon request of a claimant, the Appeals Committee will identify the individual names of any medical or vocational experts whose advice was obtained in connection with an initial Adverse Benefit Determination of a Medical Benefits or Wage Replacement Benefits claim, without regard to whether the advice of such experts was relied upon in making the benefit determination.
- **Timing of Notice of Benefit Determination on Review** - The Appeals Committee will provide notice to the claimant, as described below, of the Plan's benefit determination on review in accordance with the following timeframes:
- **Urgent Care, Pre-Service Medical Claims** - In the case of a Pre-Service Claim for Medical Benefits that is an Urgent Care Claim, the Appeals Committee will notify the claimant of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies of the claim, but not later than 72 hours after its receipt of the claimant's appeal request. No extension of time is available for Appeals Committee determinations on the review of claims for Medical Benefits.
 - **Non-Urgent Care, Pre-Service Medical Claims** - In the case of a Pre-Service Claim for Medical Benefits that is not an Urgent Care Claim, the Appeals Committee will notify the claimant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after its receipt of the appeal request. No extension of time is available for Appeals Committee determinations on the review of claims for Medical Benefits.
 - **Post-Service Medical Benefit, Wage Replacement Benefit, Death Benefit, and Dismemberment Benefit Claims** - In the case of a Post-Service Claim for Medical Benefits or a claim for Wage Replacement Benefits, Death Benefits or Dismemberment Benefits, the Appeals Committee will notify the claimant of the

Plan's benefit determination on review within 45 days after its receipt of the appeal request. The Appeals Committee may extend this period up to an additional 45 days on a claim for Wage Replacement Benefits, Death Benefits, or Dismemberment Benefits if the Appeals Committee determines that an extension is necessary due to matters beyond the control of the Plan. Written or electronic notification of an extension must be provided to the claimant prior to the expiration of the initial 45-day period and indicate the special circumstances requiring the extension and the date by which the Plan expects to render a decision.

- **Manner and Content of Benefit Determination on Review** - The Appeals Committee will provide a claimant with written or electronic notification of the Plan's benefit determination on review. If the decision on review is an Adverse Benefit Determination, the notice must satisfy all the requirements set forth in the first six bullets under the "Manner and Content of Adverse Benefit Determination" section above, and also state that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for Plan benefits.
- **Extension of Time Frames Allowed by Law or Agreement** - In the event that ERISA rules and regulations permit additional time for decisions or actions by the Claims Administrator or Appeals Committee, the Claims Administrator or Appeals Committee may exercise their discretion to utilize (but not exceed) those extended time frames; provided, however, that this discretion will only be exercised when necessary to provide a full and fair review of a claimant's right to benefits in accordance with the terms of this Plan (for example, additional time is needed to obtain an appointment and results of a medical examination). Upon request by the Plan, a claimant may also voluntarily agree to an extension or further extension of any time period within which the Plan must decide a claim.
- **Exhaustion of Administrative Remedies:** No legal action can be brought by or with respect to you to recover benefits under the Plan before the foregoing claim procedures have been exhausted. Every ERISA right of action by you, your Representative, Beneficiary or estate against the Plan, or any Plan fiduciary, must be brought no later than one (1) year from the date that the foregoing claim procedures have been exhausted (due to claimant inaction, claimant receipt of a final Adverse Benefit Determination on appeal, or otherwise). Unless contrary to applicable law, any ERISA right of action or other legal action challenging a Plan decision shall be brought in the United States District Court for the Northern District of Texas, Dallas Division.

OFFSET, REIMBURSEMENT, AND RECOVERY OF BENEFIT

Offset For Other Benefits

Benefit payments under this Plan shall be reduced by:

- the amount of any applicable federal or state income, employment, or other taxes that are required by law to be withheld;
- your earnings from any employer after disability begins, amounts legally garnished, and your contributions (through salary reduction or otherwise) to a cafeteria plan, or other pre-tax salary deferral employee benefit plan if such plan permits contributions from the participant's wage replacement benefit payments under this Plan; and
- except as otherwise specified in the Plan's "Coordination of Benefits" section, any amount paid or available with respect to your Injury under the following: Social Security Act, the Railroad Retirement Act, workers' compensation law, unemployment compensation law, occupational disease law or any other government program or similar law. The Plan shall deduct from Plan benefits the estimated benefit amounts for which you are likely to be eligible under such other deductible sources of income, regardless of whether you actually apply for such other deductible source of income.

Coordination Of Benefits

If you are covered under this Plan and one or more other benefit plans, then (unless otherwise subject to the "Subrogation and Reimbursement Rights" section) any Medical Benefits and Wage Replacement Benefits payable under this Plan will be either regular benefits or reduced benefits that, when added to the benefits of the other plan(s), will not exceed 100% of the amount described herein. The purpose of this provision is to prevent duplicate payments under plans that would exceed 100% of the benefits described in this Plan. In the coordination of benefits, one of the plans will be designated as the primary plan and the other plans will be designated as secondary. The primary plan will pay its full benefits first, then the secondary plan(s) will pay, but payments will be coordinated so that the total from all plans will not be more than the benefits described in this Plan.

- For purposes of this section, "other benefit plans" shall mean any health or disability-type benefits provided under (1) any individual, group, blanket or franchise plan, (2) other prepaid coverage under service plan contracts, or under group or individual plans, policies or a practice, (3) uninsured arrangements of group or group-type coverage, (4) labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans, (5) benefits coverage in a group, group-type and individual policy or policies of automobile coverage (including, but not limited to medical payment coverage, personal injury protection coverage, uninsured motorists coverage and underinsured motorists coverage, and (6) any other group-type contracts – that is, those contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.
- Except as specified below, if a person is covered by more than one plan to which this coordination of benefits provision applies, then the following rules will determine which plan will be primary:

- With respect to health benefits only, when only one of the plans has a coordination of benefits provision, then the plan without such a provision will be the primary plan;
 - The plan under which the person is covered other than as a dependent (for example, active associate, former associate, inactive associate, COBRA participant or retiree) will be the primary plan over a plan which covers the person as a dependent;
 - The plan under which the person is covered as an active associate will be the primary plan over a plan which covers the person as former associate, inactive associate, COBRA participant or retiree;
 - If none of these rules establish an order of benefit determination, then the plan that has covered the person for the longer period of time will be the primary plan.
- Any provision herein to the contrary notwithstanding, Medical Benefits payable under this Plan to or with respect to any person who is in "current employment status" as defined for purposes of Medicare, and who is eligible for benefits under Medicare, shall be primary and shall not be reduced by the amount of benefits payable to or with respect to such person under Medicare, which will be considered the secondary plan. The fact that a person is eligible for or provided medical assistance under a state plan will not be taken into account in making payments under the Plan.
- You must notify the Claims Administrator of such other benefit plans and cooperate with the Claims Administrator in (1) furnishing copies of other policies, coverages or plans which may be applicable to the Injury, and in (2) completing and returning to such Claims Administrator any questionnaire or forms inquiring about, or assigning rights to recover under, other policies, coverages or plans which may cover or be applicable to you.

Subrogation and Reimbursement Rights

In some cases, another person or insurance company may be financially responsible for your medical expenses (for example, in an automobile accident, a no-fault automobile insurance policy may be responsible for paying all or part of your medical expenses). If the Plan reimburses expenses for which you later recover damages, you are required to reimburse the Plan for those expenses. When you accept payments made on your behalf by the Plan, you agree to (i) reimburse the Plan for the full amount of payments made on your behalf, (ii) submit all documents permitting the Plan to recover the payments it made to you or to a medical professional, and (iii) provide any other assistance and cooperation to the Plan in enforcing these rights and not to do anything to obstruct the Plan. The legal term for the Plan's right of recovery is "subrogation".

For purposes of "Subrogation and Reimbursement Rights", the "Notice of Legal Proceedings," and "Assignment of Rights" sections of this Plan, the term "Payee" means you or your Beneficiary or your respective family members, heirs, estate, or other

Representative (in their individual or representative capacity), singularly or collectively as the context may require to give the Plan the broadest possible rights of recovery.

- **Right of Subrogation** - If a Payee becomes entitled to or directly or indirectly receives Plan benefits for any Injury caused by the negligence or other act or omission of any person or organization (including, but not limited to, the Employer), and is (or later becomes) entitled to or otherwise collects any damages or other compensation in connection with such Injury (including, but not limited to, damages for negligence, survival, wrongful death or other legal or equitable action), whether by insurance, litigation, settlement or other proceeding, the Payee shall automatically be required to (i) subrogate his, her or its right to and reimburse the Plan out of said damages or other compensation to the extent of the Plan benefits paid to, or with respect to, the Payee and (ii) subrogate his, her or its right to and reimburse the Plan out of said damages or other compensation for all medical management, investigation, attorneys' fees, costs of recovery, and other expenses related to the claim for benefits (including any subrogation proceeding). The subrogation rights of this Plan even apply with respect to a Payee who is (or later becomes) entitled to or otherwise collects any damages or other compensation in connection with such Injury but has not and will not receive any Plan benefits if such person's claim for damages or other compensation is dependent on whether the participant had or has a valid claim against a third party. In the sole and exclusive discretion of the Claims Administrator and in consideration of all relevant facts and circumstances, the Claims Administrator may waive its right of subrogation.
- **Written Confirmation** - Upon request of the Plan, the Payee shall provide the Plan written confirmation of this subrogation right, including execution of any assignment, lien form or other document requested by the Claims Administrator to enable the Plan to recover such Plan benefits and related expenses. Any failure of a Payee to give written confirmation of the Plan's subrogation rights does not adversely affect its rights of subrogation because the Plan's right of subrogation arises automatically once payment under this Plan is made to or on behalf of the Payee.
- **Right to Reimbursement** - If (i) a Payee fails, refuses or neglects to reimburse the Plan or otherwise comply with the provisions of this section, or (ii) payments are made under the Plan based on fraudulent information or otherwise in excess of the amount necessary to satisfy the provisions of the Plan, then the Plan shall still have all remedies and rights of recovery specified herein. The Plan shall also have the right to terminate or suspend benefit payments and/or recover the reimbursement of all amounts above due to the Plan by withholding, offsetting and recovering such amounts out of any future Plan benefits or amounts otherwise due from the Plan to or with respect to such Payee.
- **Right of Recovery** - The Plan shall have the first lien recovery against any benefits paid or to be paid by the Plan, meaning that the Plan has the first right of recovery, regardless of whether the covered person has been made whole. The Plan shall also have the right to bring a lawsuit and assert a constructive trust or other interest against any and all persons that have assets to which the Plan can claim rights. The

Plan has the right of first recovery from any judgment, settlement or other payment, regardless of whether the Payee has been "made whole."

- **Attorney's Fees and Expenses** - The Plan's subrogation rights and first lien will not be reduced by attorneys' fees or expenses incurred by any party in pursuing recovery against a third party. The "common fund" doctrine (or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement) shall not apply. Any attorneys' fees and/or expenses incurred by or at the request of the Payee or his, her or its attorneys in a third party or other action shall be the sole responsibility of such party.

Notice of Legal Proceedings

You must notify the Claims Administrator when you take legal action against a third party as a result of an illness or injury, or if a third party is responsible for payment. Accordingly, a Payee (whether or not such person has received or may in the future directly or indirectly receive Plan benefits) shall provide the Claims Administrator with prior written notice of the involvement of such party in any lawsuit, settlement discussion or other proceeding (for negligence, wrongful death, survival or other cause of action), one of the principal purposes of which is recovering, from any person or organization, damages or other compensation in any way related to any injury for which Plan benefits have been or may in the future be paid. The Plan shall have the right to intervene for itself and on behalf of a Payee in any such lawsuit, settlement discussion or other proceeding. If a Payee neglects, fails or refuses to seek a recovery from any person or organization for any injury caused by the negligence or other act or omission of such person or organization, the Plan shall have the right to institute a lawsuit or other proceeding or do any other act that in the opinion of the Claims Administrator may be necessary or desirable to recover the Plan benefits paid (and to be paid in the future), plus all medical management, investigation, attorneys' fees, costs of recovery, and other expenses incurred by the Plan.

Assignment of Rights

By participating in this Plan, a participant obligates himself or herself, as well as all other Payees (in both their individual and representative capacities), to the provisions of this Plan, including, without limitation, the "Subrogation and Reimbursement Rights," "Notice of Legal Proceedings," and "Assignment of Rights" sections hereof. What this means is, that, upon the request of the Claims Administrator, a Payee shall assign to the Plan the right to intervene in or institute any lawsuit, settlement discussion, or other proceeding described in the "Subrogation and Reimbursement Rights," and "Notice of Legal Proceedings," sections, and to use the name of such party for such purpose. The Plan shall have the right to select legal counsel of its own choice and such counsel shall have complete control over the conduct of any such lawsuit, settlement discussion, or other proceeding without the consent or participation of any such Payee. Whenever the Plan shall intervene in or institute any lawsuit or other proceeding as permitted by the provisions of this section, the Plan may pursue same to a final determination and the Plan expressly reserves the right to appeal from any adverse judgment or decision. The

Payee shall give the Plan all reasonable aid in any such lawsuit, settlement discussion, or other proceeding in effecting settlement, in securing evidence, in obtaining witnesses, or as may otherwise be requested by the Claims Administrator. The Payee shall release the Plan, the Employer, the Plan Administrator, the Claims Administrator, the Appeals Committee, and their respective directors, officers, agents, consultants, attorneys, and associates from all claims, causes of action, damages and liabilities of whatever kind or character that may directly or indirectly arise out of the pursuit or handling by the Plan of any such lawsuit, settlement discussion or other proceeding.

There is no assignment of benefits under the Plan. You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void. The payment of benefits directly to a health care provider, if any, shall be done as a convenience and shall not constitute an assignment of benefits under the Plan.

Right To Receive And Release Necessary Information

For the purposes of determining the applicability and implementation of the terms or provisions of this Plan, the Claims Administrator may, without the consent of or notice to any person or organization, release to or obtain from any person or organization, information considered necessary for these purposes. When you request benefits, you must furnish all information requested by the Claims Administrator.

APPLICABLE LAW

This Plan shall be governed and construed in accordance with the provisions of ERISA and, except where superseded by federal law, the laws of the State of Texas. This Plan is exempt from the group health plan requirements of:

- Part 7 of ERISA by operation of one or a combination of the excepted benefits listed in ERISA Section 733(c)(1) and is therefore exempt from the standards, rules, regulations and other requirements of the Health Insurance Portability and Accountability Act ("HIPAA"),
- The Public Health Service Act by operation of one or a combination of the excepted benefits listed in Title 42 of the United States Code Section 300gg-91(c)(1) and is therefore exempt from the standards, rules, regulations and other requirements of the Patient Protection and Affordable Care Act ("PPACA").
- Any other standards, rules, regulations or other requirements that utilize or reference the excepted benefits definition listed in ERISA Section 733(c)(1).

AMENDMENT OR TERMINATION OF PLAN

The Company presently intends to continue the Plan indefinitely, but the Company reserves the right to amend, suspend, modify, or terminate the Plan (or any portion of the Plan) for any reason at any time (in writing); provided, however, that no such

amendment or termination will reduce the amount of any benefit payable to, or with respect to, you under the Plan in connection with an Injury occurring prior to the date of such amendment or termination. If the Plan is terminated, your subsequent coverage under the Plan will end. Any such amendment or termination will be adopted pursuant to formal written action of a representative authorized to act on behalf of the Company.

DEFINITIONS

This section defines specific terms used in this booklet. These definitions should not be interpreted to extend coverage unless specifically provided for in the other sections of this booklet and the Plan document.

Adverse Benefit Determination

A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a Plan benefit. For example, this includes denial, reduction or termination of benefits based upon (1) your ineligibility to participate in the Plan, (2) application of any utilization review, (3) a medical service being considered experimental, investigational or not medical necessary, or (4) you are no longer Disabled.

Appeals Committee

The individuals or entity appointed by the Company to make determinations on appeal of benefit claims.

Approved Facility

A hospital, other medical care facility or other medical service or supply provider either expressly approved by the Claims Administrator, included on an approved list of facilities adopted by the Claims Administrator or otherwise approved in writing by the Claims Administrator upon the request of a Plan participant. Where the authorized prescription, medical supply or service is available at a Walmart or Sam's Club location convenient to the participant, Walmart or Sam's Club is the exclusive Approved Facility for such authorized prescription, medical supply or service.

Approved Physician

A person duly licensed under applicable state law as a Medical Doctor or Doctor of Osteopathy and either expressly approved by the Claims Administrator, included in an approved list of physicians adopted by the Claims Administrator, or otherwise approved in writing by the Claims Administrator upon the request of a Plan participant.

Beneficiary

The person or persons determined in the following priority:

- If there is an Eligible Spouse, all Death Benefits shall be paid to the Eligible Spouse.

- If there is no Eligible Spouse, Death Benefits shall be paid in equal shares to the Eligible Children. If an Eligible Child has predeceased the participant, Death Benefits that would have been paid to that child if he or she had survived the participant shall be paid in equal shares per stirpes to the children of such deceased child.
- If the participant is not survived by an Eligible Spouse or Eligible Child, any Death Benefits shall be paid to a surviving dependent (as determined in accordance with the support criteria set forth in section 152 of the Internal Revenue Code and such other rules as the Claims Administrator may prescribe) of the participant who is a parent, sibling, or grandparent of the deceased participant. If more than one of those dependents survives the participant, any Death Benefits shall be divided among them in equal shares.
- If the participant is not survived by an Eligible Spouse, Eligible Child, or dependent who is a parent, sibling, or grandparent, the Death Benefits shall be payable to the Associate Critical Needs Trust for the benefit of Company associates.
- For purposes of this Section:
 - "Eligible Spouse" means the surviving spouse of the deceased participant, recognized by a marriage certificate issued under the laws of the State of Texas or similar government authority, or by a Texas court decree of common law marriage (obtained at such person's sole initiative and expense).
 - "Eligible Child" means a surviving child of the deceased participant, whether by blood, marriage, or legal adoption, if the child is:
 - under 18 years of age;
 - enrolled as a full-time student in an accredited educational institution and is less than 25 years of age; or
 - because of a physical or mental handicap, a dependent (as determined in accordance with the support criteria set forth in section 152 of the Internal Revenue Code and such other rules as the Claims Administrator may prescribe) of the deceased Participant at the time of the participant's death.

Claims Administrator

The individual, individuals or entity appointed by the Company to make initial determinations of benefit claims under this Plan on behalf of the Employer.

Course and Scope of Employment

An activity of any kind or character for which you were hired and that has to do with, and originates in, the work, business, trade or profession of the Employer, and that is

performed by you in the furtherance of the affairs or business of the Employer. The term includes activities conducted on the premises of the Employer or at other locations designated by the Employer. This term does not include:

- transportation to and from your place of employment, unless:
 - the transportation is furnished as part of your employment arrangement or is paid for by the Employer; provided, however, that this exception does not include commuting to or from your usual place of employment;
 - the means of the transportation are under the control of the Employer; or
 - you are directed in your employment to proceed from one place to another place. Commuting to the place where you begin Employer business and commuting away from the place where you cease Employer business will not be covered if such transportation is not paid for by the Employer or otherwise under Employer control.
- travel by you in furtherance of the affairs or business of the Employer if such travel is also in furtherance of personal or private affairs by you, unless:
 - the travel to the place where the Injury occurred would have been made even had there been no personal or private affairs by you to be furthered by the travel; and
 - the travel would not have been made had there been no affairs or business of the Employer to be furthered by the travel.
- your transportation not under dispatch or other activity not under dispatch;
- any injury occurring before you clock in or otherwise begin work for the Employer, or after you clock out or otherwise cease work for the Employer,
- any injury occurring while you are on a work break, unless (1) the injury occurs while you are on a work break on the Employer's premises, (2) such work break was authorized by your supervisor (or was otherwise permitted consistent with your job description), and (3) you have not clocked out or otherwise ceased work or concluded your shift for the Employer.

Disabled or Disability

A Total Disability or a Partial Disability:

- A "Total Disability" means a medically demonstrable anatomical or physiological abnormality caused by an Injury, and commencing within six months from the date of Injury, which causes you to be -
 - temporarily unable to perform the normal duties for which you were employed;

- under the regular care of an Approved Physician; and
 - temporarily unable to engage in Temporary Alternative Duty or any other occupation for wage or profit.
- A "Partial Disability" means a medically demonstrable anatomical or physiological abnormality caused by an Injury that results in you being –
- unable to fully perform the normal duties for which you were employed;
 - under the regular care of an Approved Physician;
 - released to Temporary Alternative Duty by such Approved Physician; and
 - working for the Employer in a Temporary Alternative Duty position approved by the Employer.

Emergency Care

A service or supply provided with respect to a medical condition manifesting itself by a sudden and unexpected onset of acute symptoms of sufficient severity that in the absence of immediate medical attention could reasonably be expected to (1) result in death, disfigurement, or permanent disability, or (2) result in substantial impairment of any bodily organ, part, or function.

Maximum Benefit Limit

The maximum amount of all benefits payable to you under the Plan with respect to an Injury. Payments made for each form of benefit will be counted towards the Maximum Benefit Limit amount. The Maximum Benefit Limit for this Plan is \$300,000; provided, however, that the aggregate amount of the Maximum Benefit Limits with respect to claims of all participants arising out of a single Accident, or related series of Accidents, or Occupational Disease or Cumulative Trauma exposure, will not exceed \$1,000,000. This aggregate amount may proportionally reduce the Maximum Benefit Limit applicable to each participant involved in such Accident, related series of Accidents, or exposure, in such manner as the Claims Administrator or Appeals Committee may determine.

Maximum Rehabilitative Capacity

The earliest date after which, based upon reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated.

Plan

Walmart Stores, Inc. Texas Injury Care Benefit Plan

Plan Administrator

The Company is the plan administrator of the Plan for purposes of ERISA. The Plan is administered on behalf of the Company by the Claims Administrator and Appeals Committee.

Subject to the Plan claim procedures, both the Claims Administrator and the Appeals Committee have discretionary authority to interpret and implement the provisions of the Plan. Any failure by the Claims Administrator or Appeals Committee to apply any provisions of this Plan to any particular situation shall not represent a waiver of the Claims Administrator's or Appeals Committee's authority to apply such provisions thereafter. Every interpretation, choice, determination, or other exercise of authority by the Claims Administrator or Appeals Committee will be binding upon all affected parties, without restriction, however, on the right of the Claims Administrator or Appeals Committee to reconsider and redetermine such action. There shall be no de novo review by any arbitrator or court of any decision rendered by the Appeals Committee and any review of such decision shall be limited to determining whether the decision was so arbitrary and capricious as to be an abuse of discretion. The Claims Administrator or Appeals Committee may adopt any rules and procedures it considers necessary or appropriate for the administration of the Plan. The Claims Administrator or Appeals Committee may deny a claim for or suspend the payment of Plan benefits otherwise payable to you if you do not comply with any provision of the Plan or the rules and procedures adopted by the Claims Administrator or Appeals Committee. **Notwithstanding the foregoing, the Appeals Committee shall have final authority regarding any decision made with respect to the administration of the Plan.**

The Plan Administrator will administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated.

Post-Service Claim

Any claim for a Medical Benefit that is not a Pre-Service Claim.

Preexisting Condition

Any associate illness, injury, disease, impairment or other physical or mental condition, whether or not work-related, which originated or existed prior to the date of the Injury.

Pre-Injury Pay

- For a salaried participant, regular bi-weekly salary from the Employer at the time of the Injury; and
- For an hourly participant, the average earnings from the Employer for the 12 consecutive weeks immediately preceding the date of Injury; provided, however, that if such a participant has been employed for less than 12 consecutive weeks, or if his or her earnings as of such date cannot be reasonably determined (in the judgment of the Claims Administrator), such 12-week average will be based upon the earnings received over such period by a similar associate of the Employer.

"Pre-Injury Pay" will include pay for overtime and participant contributions (through salary reduction or otherwise) to a 401(k) arrangement, cafeteria plan, or other pre-tax salary deferral employee benefit plan. "Pre-Injury Pay" will not include any bonuses, benefits (including, but not limited to, Employer contributions to any employee benefit

plans or matching contributions to a retirement plan) or other extraordinary remuneration.

Pre-Service Claim

Any claim for Medical Benefits with respect to which this Plan requires Claims Administrator approval in advance of obtaining medical care.

Representative

A person that a participant authorizes in writing to act on his/her behalf. The Plan will also recognize a legally valid power of attorney or a court or administrative agency order giving a person authority to take an act on a participant's behalf. In the case of an Urgent Care Claim, a physician with knowledge of the participant's condition may act as the participant's Representative.

Receipt, Safety Pledge and Arbitration Acknowledgement

The form attached as Appendix D to the back of this SPD booklet.

Temporary Alternative Duty

A temporary accommodation that allows you to perform your regular job, or an alternate, temporary job that complies with your work restrictions and the Employer's needs.

Urgent Care Claim

Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent Pre-Service Claim determinations (generally, 15 days after the Claims Administrator's receipt of the claim):

- could seriously jeopardize your life or health or your ability to regain maximum function; or
- in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The determination of whether a claim is an Urgent Care Claim as described above shall be made by the Claims Administrator applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a physician with knowledge of your medical condition determines that a claim is an Urgent Care Claim and clearly communicates such determination to the Claims Administrator, the Plan shall treat the claim as an Urgent Care Claim for purposes of this Plan.

The characterization of a claim as an Urgent Care Claim solely impacts the timeframes and other procedures for processing benefit claims and in no way

changes this Plan's approved medical provider requirements, pre-authorization requirements, or other medical management requirements. These requirements generally provide that (1) except in the case of Emergency Care, no amount shall be considered a Covered Charge under the Plan unless treatment is pre-approved by the Claims Administrator and furnished by or under the direction of an Approved Physician or Approved Facility, and (2) all determinations relating to your physical condition (upon which the payment of benefits is based) must be made by an Approved Physician. Urgent Care Claims may not arise to the level of Involving Emergency Care. Your decision to seek treatment from an urgent care clinic or hospital emergency room does not necessarily result in an Urgent Care Claim or involve Emergency Care. See the MEDICAL BENEFITS and DETAILED CLAIM PROCEDURES sections of this booklet for more information.

Violent Crime

Any act involving, or of the nature of, a violent crime, including, but not limited to, armed robbery, that would result in severe shock to a reasonable person.

GENERAL INFORMATION

Type Of Plan and Administration

The Plan is a welfare benefit plan providing wage replacement, death, dismemberment and medical benefits (including certain dental and vision benefits) due to an Injury. The Plan is administered by the Claims Administrator and Appeals Committee to the extent such duties have been delegated to the Claims Administrator and Appeals Committee by the Plan Administrator.

Name And Address Of Primary Plan Sponsor

Walmart Stores, Inc.
P.O. Box 1288
Bentonville, Arkansas 72712

A list of the employers participating in this Plan is attached to the back of this booklet as Appendix B.

Name and Address Of Plan Administrator

Any questions you may have about the Plan may be posed to the Plan Administrator by mail, c/o Senior Director of Risk Management, Walmart Stores, Inc., P.O. Box 1288, Bentonville, Arkansas 72712, or by telephone at 1-800-527-0566.

Name And Address Of Person Designated As Agent For Service Of Legal Process

Jennifer D. Hurless, J.D.
1025 W Trinity Mills Rd. #120
Carrollton, TX 75006

Service of legal process may also be made upon the Plan Administrator.

Employer And Plan Identification Numbers

The employer identification number assigned by the Internal Revenue Service to Walmart Stores, Inc. is 71-0415188. The plan number of the Plan is 502.

Plan Year

The Plan operates and keeps its records on the basis of the 12-month period ending each January 31.

Not a Contract of Employment

None of the provisions of any of the Plan documents are considered a contract of employment between you and the Employer, nor does your participation in the Plan provide any guarantee of continued employment. The Employer's rights with regard to disciplinary action and termination of any associate, if necessary, are in no manner changed by any provision of the Plan documents.

COBRA RIGHTS STATEMENT

The Plan shall comply with the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). The Plan Administrator shall have full power and discretion to interpret the extent to which such requirements are applicable or appropriate to the Plan.

ERISA RIGHTS STATEMENT

As a participant in the Plan, you are entitled to certain rights and protections under a federal law that governs employee benefit plans, referred to as the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as work sites) all documents governing the Plan, including insurance contracts (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

Continue group health coverage for yourself if there is a loss of coverage under the Plan as a result of a qualifying event. You may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights. See also Appendix C to this Summary Plan Description.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including the Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have brought a claim against to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if

you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

March 1, 2012

APPENDIX A

ARBITRATION OF CERTAIN INJURY-RELATED DISPUTES

ARBITRATION POLICY OVERVIEW

The Employer hereby adopts a mandatory company policy requiring that certain claims or disputes must be submitted to final and binding arbitration under this arbitration requirement ("Policy"). **This binding arbitration will be the sole and exclusive remedy for resolving any such claim or dispute. For purposes of this Policy only, "Employer" or "Company" shall mean Walmart Stores, Inc., and its successors or assigns and any other entity affiliated, owned or related to Walmart Stores, Inc. for which an associate has or may have standing to sue.**

(a) Covered Claims:

- (1) any legal or equitable claim or dispute relating to enforcement or interpretation of the arbitration provisions in a Receipt, Safety Pledge and Arbitration Acknowledgement form, associate training program, or this Policy; and
- (2) any legal or equitable claim by or with respect to an associate for any form of physical or psychological damage, harm or death which relates to an accident, occupational disease, or cumulative trauma (including, but not limited to, claims of negligence or gross negligence or discrimination; claims for intentional acts, assault, battery, negligent hiring/ training/ supervision/ retention, emotional distress, retaliatory discharge, or violation of any other noncriminal federal, state or other governmental common law, statute, regulation or ordinance in connection with a job-related injury, regardless of whether the common law doctrine was recognized or whether the statute, regulation or ordinance was enacted before or after the effective date of this Policy).
- (3) The determination of whether a claim is covered by this Policy.

This arbitration requirement includes all claims listed above that an associate has now or in the future against an Employer, its officers, directors, owners, associates, representatives, agents, subsidiaries, affiliates, successors, or assigns (even if such claim relates to matters occurring before the effective date of this Policy, if the associate has not filed a legal action in any court or with any governmental agency prior to such date).

(b) Excluded Claims: This arbitration requirement does not, however, include the following claims:

- (1) any legal or equitable claim under ERISA for benefits, fiduciary breach, or other problem or relief solely relating to benefits payable under this Plan. If an associate wishes to appeal a denial of benefits under the Plan, such associate must follow the process described in ARTICLE VI of the Plan. After exhausting the appeal process outlined in ARTICLE VI of the Plan, any action challenging a Plan decision, or any other ERISA right of action, must be brought in the United States District Court for the Northern District of Texas, Dallas Division.

- (2) Any claim filed with an administrative agency in accordance with applicable law.
 - (3) Any criminal act or complaint, including but not limited to, restitution by an associate for a criminal act for which he or she has been found guilty or no contest, or if the criminal proceedings have been resolved by deferred adjudication.
- (c) **Covered Parties:** Neither an associate nor an Employer shall be entitled to a bench or jury trial on any claim covered by this Policy. This Policy applies to all associates without regard to whether they have completed and signed a Receipt, Safety Pledge and Arbitration Acknowledgement form or similar written or electronic receipt. These provisions also apply to any claims that may be brought by an associate's spouse, children, parents, beneficiaries, Representatives, executors, administrators, guardians, heirs or assigns (including, but not limited to, any survival or wrongful-death claims).

ARBITRATION PROCESS

- (a) **Required Notice of All Claims:** When a party seeks arbitration, such party must give written notice of any claim to the Judicial Workplace Arbitrations, Inc. ("JWA") and the other party within the applicable statute of limitations for such claim. The day the act complained of occurred will be counted for purposes of determining the applicable period. If such notice is not given timely and in the manner described above, the claim shall be void and deemed waived. **The filing of a lawsuit will not toll the running of the applicable statute of limitations to request arbitration of a claim, nor will the doctrine of equitable tolling apply to extend the limitations period for the party to request arbitration.**
- (1) The party requesting arbitration must send written notice in triplicate to the Judicial Workplace Arbitrations at 941 Barnett, Kerrville, Texas 78028. If an associate wishes to invoke arbitration, the associate must also send written notice to the Employer, in care of Jennifer D. Hurless, c/o CMI, 1025 W Trinity Mills Rd. #120 Carrollton, TX 75006 (or such other person or address as the Employer may specify). If the Employer wishes to invoke arbitration, the Employer must also give written notice to the associate at the last address recorded in the associate's personnel file.
 - (2) The party requesting arbitration must file a petition with JWA specifically identify and describe in the written notice all claims asserted and the facts on which the claims are based. This written notice shall be sent to JWA and the other party by certified or registered mail, return receipt requested. The responding party shall file a responsive pleading setting forth its defenses and shall have the ability to file special exceptions with the arbitrator on the basis that the petition does not satisfy the requirements of this arbitration requirement. The form and timing of these pleadings shall follow the deadlines in the Texas Rules of Civil Procedure.
 - (3) If after expiration of the applicable statute of limitation (i) a court has ordered the parties to arbitrate, and (ii) such court or arbitrator for whatever reason has determined that the claim is not void and deemed waived, then the party that is compelled to arbitrate must give notice of such claim to JWA and serve the other

party with 30 days of such order or the party's claim shall be void and deemed waived. Such notice must be given in the manner described above.

- (b) **Arbitration Filing Fees:** The associate shall pay a nonrefundable arbitration filing fee equal to the standard associate filing fee specified under then-current JWA Arbitration Procedures. The associate's filing fee must be paid when he or she submits a request for arbitration (or, if this process is challenged by an associate, when arbitration is compelled by court order). The Employer shall pay a nonrefundable arbitration filing fee equal to the standard employer filing fee specified under then-current JWA Arbitration Procedures. The Employer will also pay the arbitrator's entire fee and any other JWA administrative expenses; provided, however, that an associate may elect to also pay up to one-half of these fees and expenses. The arbitrator shall state his or her hourly rate in writing prior to the time that the arbitrator is selected. The arbitrator's rate shall not change during the pendency of a case. If the arbitrator must travel, the time spent in travel and reasonable travel expenses shall be paid as specified above.
- (1) If the arbitrator finds completely in favor of the associate on all claims, the Employer will reimburse the associate for his or her share of the filing fee.
 - (2) If the Employer initiates the arbitration (by means other than a motion in court to compel arbitration), the associate will pay no portion of the JWA or arbitrator filing fees.
- (c) **Choosing an Arbitrator:** Absent express agreement between the parties to the contrary, JWA arbitrations shall be conducted by a single arbitrator. The parties to the dispute shall be presented a panel with a minimum of three different prospective JWA arbitrators from whom they shall choose. The parties may agree to the selection of one particular arbitrator from the panel. If agreement is not reached, the plaintiff(s) and defendant(s) shall have an equal number of strikes. Plaintiff(s) and defendant(s) shall each strike one arbitrator from the panel. The parties shall continue to strike arbitrators from the panel until one arbitrator remains. That person shall then arbitrate the claim. If for any reason, this method does not result in the selection of one arbitrator, JWA shall select the arbitrator.
- (1) Unless otherwise agreed to in writing by the parties, the arbitrator selected by the parties in accordance with those rules (1) shall be a former judge (and/or attorney licensed to practice in the State of Texas) with experience in personal injury litigation, and (2) shall be selected from a panel of arbitrators located in Dallas County, Texas.
 - (2) The prospective arbitrator shall disclose any financial interest or relationship with any of the parties of which the prospective arbitrator is aware. Any party may challenge the qualifications or neutrality of an arbitrator by presenting a written objection within ten (10) days after receiving an arbitrator's disclosure. The non-challenging party may either agree or file a response to the objection within ten (10) days of receiving the objection. JWA will review any objection and determine whether a particular objection is valid. JWA's decision is conclusive on this matter.

- (3) After the selection process is completed, if the arbitrator so selected becomes unable to serve for any reason, the parties shall again go through the same selection process described above.
- (d) **Scheduling Order:** Within a reasonable time after the arbitration has commenced, the arbitrator shall issue a scheduling order setting forth deadlines, including without limitation, such items as deadlines for discovery to be completed, parties to be joined, pleadings to be filed or amended and setting forth a hearing date.
- (e) **Discovery and Motion Practice:** Parties to the arbitration may use all discovery devices (interrogatories, requests for production, admissions, depositions, etc.) that are allowed under the Texas Rules of Civil Procedure. Any party may also make motions, including dispositive motions, that can be filed in Texas state court (or Federal court, if applicable).
- (f) **Pre-Arbitration Remedies:** The arbitrator may award relief to a party, including injunctive relief, prior to the final hearing for arbitration. The arbitrator may postpone any hearing with the mutual agreement of the parties or by any party's request with good cause shown. The arbitrator may also direct the parties to mediation prior to the arbitration hearing. If the parties cannot agree to a mediator, the arbitrator shall appoint one. Mediation is a nonbinding process. The parties meet and with the help of a mediator attempt to reach a settlement of a dispute. The settlement must be acceptable to both parties and the mediator cannot impose a settlement upon a party.
- (g) **Arbitrator Authority:** The arbitrator, and not any federal, state, or local court or agency, shall have exclusive authority to resolve any dispute relating to the interpretation, applicability, enforceability or formation of this agreement including, but not limited to, any claim that all or any part of this agreement is void or voidable.
 - (1) At any time, the arbitrator will have the authority to consider and grant motions consistent with the Texas Rules of Civil Procedure (or Federal Rules of Civil Procedure, if applicable), including, but not limited to, motions for summary judgment.
 - (2) The arbitrator is authorized only to rule on the claims set forth in the original written notice, any counterclaim(s), and the answer(s) made to such claims and counterclaims. The arbitrator is not authorized to modify the powers granted to him or her under this Policy or to make any award merely on the basis of what he or she determined to be just or fair.
 - (3) The arbitrator shall also not commingle the standards for state law determinations and remedies (for example negligence claims and special damage awards) with the standards for federal law determinations and remedies that may or may not be subject to this Policy (for example, ERISA benefit eligibility and ERISA damage awards are not subject to arbitration).
- (h) **Arbitration Procedures:** Any arbitration under this Policy will be administered by the Judicial Workplace Arbitrations, Inc. ("JWA") under its then-current JWA Arbitration Procedures.

- (1) **Preliminary Hearing:** After arbitrator selection, a preliminary hearing may be scheduled upon request by the parties, the JWA or the selected arbitrator. At this hearing, the arbitrator will work with the parties to narrow the issues, establish a discovery schedule, arrange for an acceptable procedure for the filing of any motions and arrange for the earliest and most efficient arbitration hearing possible for the issues in dispute.
 - (2) **Discovery:** The arbitrator will have discretion to order pre-hearing exchange of information, including but not limited to, document production, information requests, depositions, subpoenas, and summaries of expected testimony. The arbitrator can issue protective orders as he or she deems necessary or appropriate to protect the privacy or other legal rights of the parties and/or witnesses.
 - (3) **Recording the Hearing:** Either party may arrange for, and pay the cost of, a court reporter to provide a stenographic record of the proceedings. Otherwise, the arbitration hearing will not be recorded.
 - (4) **Attorney Fees:** Each party shall be responsible for their own attorney's fees, if any. However, if any party prevails on a statutory claim which allows the prevailing party to be awarded attorney's fees, or if there is a written agreement providing for such fees, the arbitrator may award reasonable attorney's fees to the prevailing party.
 - (5) **Other Arbitration Expenses:** Each party shall also be responsible for any costs for witnesses called, any costs to produce evidence requested by the other party, deposition costs, and transcripts. The Employer will pay fees and expenses charged by the arbitrator or the JWA for the arbitration; however, the associate may elect to pay up to one-half of these fees and expenses if requested.
 - (6) **Failure to Attend:** If you or the Employer fail to attend a scheduled arbitration hearing without good cause (as determined by the arbitrator), any claim brought by the party failing to attend will be dismissed and cannot be pursued further.
- (i) **Arbitration Decision:** Unless the parties agree otherwise, the arbitrator will make a final and binding decision within 30 days after the hearing is closed. The final decision and the arbitration award, if any, shall be made consistent with the remedies available under the state or federal statute, common law, code or regulation that is the subject of the claim. Judgment on any award by the arbitrator may be entered into any court having jurisdiction over the claim and shall have the same legally binding effect as if the judgment had been rendered in such court.
- (1) **The arbitrator's decision shall be rendered in writing and include a brief summary of all findings of fact and conclusions of law necessary to support the arbitrator's decision.**
 - (2) The arbitrator shall assess the JWA filing fee, arbitrator fees and expenses, and attorney's fees against a party upon a showing by the other party that the first party's claim is frivolous, or unreasonable, or factually or legally groundless.

- (3) All decisions rendered by an arbitrator under this Policy will be kept confidential by all parties, and shall not serve as binding, legal precedent with respect to subsequent claims or disputes under this Policy.
- (3) An arbitrator's decision can be challenged in a state or federal court of law only on such basis as are available under the Federal Arbitration Act.

ADDITIONAL INFORMATION

- (a) **Interstate Commerce and Venue:** The Employer is engaged in transactions involving interstate commerce (for example, purchasing goods and services from outside Texas which are shipped to Texas, or traveling on interstate roadways) and the associate's employment involves such commerce. The Federal Arbitration Act shall govern the interpretation, enforcement, and proceedings under the arbitration provisions of this Policy. Unless contrary to applicable law, any lawsuits seeking to enforce or vacate an arbitration award shall be brought in the United States District Court for the Northern District of Texas, Dallas Division.
- (b) **Binding Effect:** This Policy for resolving claims by arbitration is equally binding upon, and applies to any such claims that may be brought by, an Employer and each associate and his/her spouse, children, parents, beneficiaries, representatives, executors, administrators, guardians, heirs or assigns (including, but not limited to, any survival or wrongful-death claim). This binding arbitration will be the sole and exclusive remedy for resolving any such claim or dispute.
 - (1) This Policy applies to each associate and the Employer without regard to whether they have completed and signed a Receipt, Safety Pledge and Arbitration Acknowledgement form or similar written receipt. Adequate consideration for this Policy is represented by, among other things, eligibility for (and not necessarily any receipt of) benefits under this Plan and the fact that it is mutually binding on both the Employer and associates. Any actual payment of benefits under this Plan to or with respect to an associate shall serve as further consideration for and represent the further agreement of such associate to the provisions of this Policy. This Policy shall remain in effect with respect to the Employer and all associates, without regard to any associate refusal of benefits under this Plan, return of benefit payments under this Plan to an Employer, ineligibility for or cessation of benefits under this Plan in accordance with its terms, or any voluntary or involuntary termination of an associate's employment with an Employer.
 - (2) This Policy is not subject to ERISA requirements or otherwise dependent upon the benefit provisions of this Plan in any way, and is included herein strictly as a matter of convenience in documentation. This Plan and Policy also in no way changes the "at will" employment status of any associate not covered by a collective bargaining agreement.
 - (3) If either party initiates a claim covered by this Policy by any means other than arbitration, the responding party shall be entitled to dismissal of such action, and the recovery of all costs and attorney's fees and expenses related to such action.

- (c) **Amendment or Termination of Arbitration Policy:** The Company shall have the right and power at any time and from time to time to amend this Policy, in whole or in part, on behalf of Employer, and at any time to terminate this Policy or any Employer's participation hereunder; provided, however, that no such amendment or termination shall alter the arbitration requirements of this Policy with respect to an Injury occurring prior to the date of such amendment or termination. In addition, any such amendment or termination of this arbitration Policy shall not be effective until at least 14 days after written notice has been provided to associates. Any such amendment or termination shall be pursuant to formal written action of a representative authorized to act on behalf of the Company.

APPENDIX B

PARTICIPATING EMPLOYERS

Walmart Stores, Inc. (Plan Sponsor)
FEIN: 71-0415188

Walmart Stores Texas, LLC
FEIN: 74-3019386

Walmart Associates, Inc.
FEIN: 71-0794409

Sam's East, Inc.
FEIN: 71-0794412

Walmart Realty Company
FEIN: 71-0505854

Claims Management, Inc.
FEIN: 71-0738006

Walmart.com, Inc.
FEIN: 71-0834007

Walmart Transportation, LLC
FEIN: 71-0862103

A list of any additional participating employers is available upon request from the Plan Administrator.

APPENDIX C

COBRA CONTINUATION COVERAGE NOTICE

The federal law requirements of *COBRA* continuation coverage (as amended from time to time) apply to group health benefits provided under the Plan. This notice is intended to inform you in summary fashion of your rights and obligations.

Please note that group health benefits provided under the Plan are limited to treatment of injuries which are sustained during the course and scope of your employment with the Company. Therefore, continuation of group health coverage would not be practical if you experienced a termination of employment with the Company for whatever reason.

In addition, if you have a covered injury during your employment with the Company, the Plan would continue to provide you with health benefits for that injury following your termination of employment (subject to the terms and limits in the Plan) unless your employment is terminated based upon gross misconduct. Therefore, termination of employment in this situation is not a *qualifying event* under COBRA because it does not result in a loss of coverage under the Plan.

Finally, the Plan does not provide coverage for dependents. Therefore, any continuation coverage provided under COBRA with respect to dependents would not be applicable to this Plan.

Under a federal law known as "COBRA," covered associates and their covered spouses and covered dependent children ("qualified beneficiaries") have the right to elect temporary health care continuation coverage at group rates when such coverage ends due to certain "qualifying events." With respect to the Plan, COBRA applies to the Plan's medical and dental benefits. This Notice informs covered associates, and their covered spouses and covered dependents, in a summary fashion of their options and obligations under COBRA.

QUALIFYING EVENTS

For covered Associates: If you are an Associate covered by the Plan's medical and/or dental benefits, you may be entitled to continue the benefits you have if you lose coverage (or if your required premiums increase) because your employment terminates or because there is a reduction in your hours worked.

For covered spouses: If you are the spouse of a covered Associate and are covered by the Plan's medical and/or dental benefits, you may be entitled to continue the benefits you have if you lose coverage (or if your required premiums increase) for any of the following reasons:

- Your spouse's employment terminates
- A reduction in your spouse's work hours
- The death of your spouse
- You become divorced or legally separated from your spouse

For covered dependent children:

If you are the dependent child of a covered Associate and are covered by the Plan's medical and/or dental benefits, you may be entitled to continue the benefits you have if you lose coverage for any of the following reasons:

- A termination of the Associate's employment
- A reduction in the Associate's work hours
- The death of the Associate
- You cease to be an eligible dependent child under the Plan

If a child is born to or placed for adoption with a covered Associate or former Associate during any period the Associate or former Associate has continued coverage under COBRA, the child may also elect COBRA coverage as a qualified beneficiary. The child's COBRA coverage period will be determined according to the date of the qualifying event that gave rise to the covered Associate's or former covered Associate's COBRA coverage.

NOTIFICATION REQUIREMENTS TO PROTECT YOUR COBRA RIGHTS

The Plan will offer you COBRA coverage only after the Risk Management Department has been notified that a qualifying event has occurred.

Under COBRA, the covered Associate, spouse or dependent child must inform the Risk Management Department within 60 days of a divorce or legal separation or a child's losing dependent status under the Plan. Notice of divorce or legal separation or loss of a child's eligible dependent status must be given by writing to the Risk Management Department at the following address:

Walmart Texas Injury Care Benefit Plan
c/o Risk Management
Attn: COBRA
922 W. Walnut
Rogers, Arkansas 72756-3540

A late notification, or notice in any other manner, will cause your rights to continuation coverage under COBRA to be forfeited. This means that if you fail to give proper notice, your coverage will terminate and you will not have the right to continue coverage under COBRA. Upon receiving notice, the Risk Management Department will notify the COBRA Administrator of the qualifying event and the COBRA Administrator will provide qualified beneficiaries additional information regarding COBRA coverage, including how to elect COBRA coverage.

Your employer has the responsibility of notifying the Risk Management Department of qualifying events that are an Associate's termination of employment, reduction in hours or death which results in a loss of Plan coverage. The Risk Management Department will then notify the COBRA Administrator of these qualifying events. The notice to the COBRA Administrator shall be provided within 30 days of the date you lose coverage as a result of the event. The COBRA Administrator, within 14 days of the date it receives notice of the qualifying event, will notify qualified beneficiaries in writing of their right to COBRA coverage. Contact the Risk Management Department if you believe under these circumstances you are entitled to a notice, but did not receive one within 60 days of the Associate's termination, reduction in hours, or death.

ELECTION PERIOD

Once the COBRA Administrator is notified that a qualifying event has occurred, it will notify qualified beneficiaries of their right to elect COBRA coverage. Generally, the right to COBRA coverage only applies to the Plan's medical and/or dental benefits covering the qualified beneficiary the day before the qualifying event. Each qualified beneficiary has a separate election right. A qualified beneficiary has 60 days to elect COBRA coverage from the later of the date coverage is lost under the Plan due to the qualifying event or the date notification is provided by the COBRA Administrator to the qualified beneficiary.

This 60-day period is the maximum election period. **If an election is not properly made within this period, all rights to elect COBRA coverage will end.** An Associate who is a qualified beneficiary or a qualified beneficiary who is the spouse of the Associate

(or was the spouse on the day before the qualifying event) may elect COBRA coverage on behalf of all of the other qualified beneficiaries with respect to the qualifying event. Also, a child's parents or legal guardian may elect COBRA coverage on behalf of a minor child, and a legal representative or the estate of a qualified beneficiary may make an election on behalf of an incapacitated or deceased qualified beneficiary. If COBRA coverage is elected and the individual pays the applicable premium, the Plan is required to provide coverage that is identical to the coverage provided to similarly situated active Associates, including those made available during a subsequent open enrollment period. If coverage is changed or modified for similarly situated active Associates, COBRA coverage may be similarly changed and/or modified for qualified beneficiaries.

LENGTH OF COBRA COVERAGE

18-month period. Each qualified beneficiary has the right to 18 months of COBRA coverage from the date of the qualifying event if coverage is lost due to the Associate's termination of employment (other than for reasons of gross misconduct) or a reduction in work hours. The 18-month period can be extended in 2 circumstances:

- **Disability:** The 18-month period may be extended to up to 29 months if the Social Security Administration determines that a qualified beneficiary is disabled. The disability must have started some time before the qualified beneficiary's 60th day of COBRA coverage and last at least until the end of the 18-month period. All qualified beneficiaries with respect to the same qualifying event as the disabled qualified beneficiary are entitled to the extension of coverage. *To be entitled to the*

extension, the qualified beneficiary must notify the COBRA Administrator of the disability determination, obtain the disability determination from the Social Security Administration and provide a copy of the determination to the COBRA Administrator. Notice of the disability determination must be provided to the COBRA Administrator within 60 days of the later of the date of the original qualifying event or the date of the disability determination and before the original 18 months of COBRA coverage ends. If notice of the disability determination is provided within the 60-day period, a copy of the disability determination may be provided to the COBRA Administrator any time before the end of the original 18-month period. If there is a final determination that the qualified beneficiary is no longer disabled, the qualified beneficiary must notify the COBRA Administrator within 30 days of the Social Security Administration determination. In that event, COBRA coverage extended beyond the 18-month period will be terminated for all qualified beneficiaries.

- **Secondary events:** An extension of the 18-month period can occur if, during the 18 months of COBRA coverage, a second qualifying event occurs (divorce, legal separation, death, or loss of status as a dependent child) which would entitle the Associate's spouse or children to 18 additional months of COBRA coverage. In these circumstances, the 18 months of COBRA coverage may be extended to 36 months from the date of the original qualifying event. The extension is not available to the Associate or former Associate. If a second event occurs, it is the qualified beneficiary's obligation to notify the COBRA Administrator within 60 days of the event by telephone or in writing, at the address and telephone number listed for the COBRA Administrator at the end of this notice. Notice in any other manner or outside this time period forfeits your right to the additional extension. In no event will COBRA coverage last beyond 36 months from the date of the original qualifying event.

If an Associate becomes entitled to Medicare and later, but within 18 months of that date, loses coverage because of a termination in employment or reduction in hours worked, the COBRA coverage period for the Associate's spouse or dependent children may be extended to 36 months from the date the Associate became entitled to Medicare while employed.

36-month period. If the original qualifying event causing the loss of coverage was the Associate's death, divorce, legal separation, or loss of status as an eligible dependent child under the Plan, then each qualified beneficiary losing coverage as a result of the event has the right to elect 36 months of COBRA coverage from the date of the qualifying event.

ELIGIBILITY AND PREMIUMS

You do not have to show that you are insurable to elect COBRA coverage. However, you must be covered under the Plan on the day before the qualifying event in order to be eligible to elect COBRA coverage. A limited exception to this rule applies to individuals who fail to return from an FMLA-approved leave of absence, children born to or placed for adoption with a covered Associate during the COBRA coverage period, and spouses whose coverage is terminated by an Associate in anticipation of divorce. The Risk Management Department or COBRA Administrator reserves the right to verify eligibility and terminate COBRA coverage retroactively if you are determined to be ineligible, fail to inform it of a change in your eligibility, or if there has been a material misrepresentation of the facts. This can occur where you fail to inform the Risk Management Department of your divorce, legal separation or ceasing to attend college, for example, so that the Plan provided coverage in circumstances in which coverage should have been terminated.

A qualified beneficiary must pay all of the applicable premium plus a 2% administration charge for COBRA coverage. These premiums may be adjusted in the future if the applicable premium amount changes. If the COBRA coverage period is extended beyond 18 months due to a Social Security Administration determination of disability, the Plan may charge up to 150% of the applicable premium during the extended period for the disabled qualified beneficiary and any nondisabled qualified beneficiaries in the disabled qualified beneficiary's coverage group. There is a grace period of 30 days for the regularly scheduled monthly premiums.

This is the maximum grace period under the Plan; the Plan does not provide for an extension beyond what is required by law.

TERMINATION OF COBRA COVERAGE

COBRA coverage will be terminated *prior to the maximum COBRA coverage period (the applicable 18-, 29- or 36-month period)* for any of the following reasons:

- Wal-Mart and its affiliated entities cease to provide group health coverage to any of its Associates.
- Any required premium is not paid in a timely fashion (taking into account the applicable grace period).
- A qualified beneficiary becomes covered, after the date on which COBRA coverage was elected, under a group health plan, including a governmental plan that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary unless such exclusion or limitation does not apply or has been satisfied by the qualified beneficiary.
- A qualified beneficiary becomes entitled to Medicare Part A or Part B benefits on a date after the date of the COBRA coverage election.
- The qualified beneficiary submits a fraudulent claim or other incorrect information.
- A qualified beneficiary notifies the COBRA Administrator that he or she wishes to cancel COBRA coverage.

Once your COBRA coverage terminates, it cannot be reinstated for any reason.

ADDRESS CHANGES

In order to ensure that you receive information properly and efficiently, please contact the Risk Management Department at the address listed below to notify it of any address changes as soon as possible. Failure on your part to do so may result in delayed notification and loss of COBRA coverage options. You should also keep a copy, for your records, of any notices you send to the Risk Management Department or COBRA Administrator.

PLAN ADMINISTRATIVE INFORMATION/QUESTIONS

If you do not understand any part of this notice, or if you have questions regarding COBRA coverage or the Plan, please contact the Risk Management Department at the address listed below. In addition, all notices required for the Plan's medical and dental benefits must be given in writing to the Risk Management Department at the following address:

Walmart Texas Injury Care Benefit Plan
c/o Risk Management Department
Attn: COBRA
922 W. Walnut Street
Rogers, Arkansas 72756-3540

The COBRA Administrator is Conexis. The address and telephone number for the COBRA Administrator are:

Conexis
Box 226101
Dallas, TX 75222
(800) 570-1863

Additional information about your rights and obligations under the Plan and federal law is available from the Risk Management Department at the address listed above. For more information about your rights under the Employee Retirement Income Security Act ("ERISA"), including COBRA, and other laws affecting this plan, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and telephone numbers of Regional and District EBSA Offices are available through EBSA's website.)

The following is to be used by guardians of minor associates and associates unable to complete and acknowledge this program through the computer based learning module.

APPENDIX D

RECEIPT, SAFETY PLEDGE AND ARBITRATION ACKNOWLEDGEMENT

RECEIPT OF MATERIALS. By my signature below, I acknowledge that I have received and read (or had the opportunity to read) the Summary Plan Description (the "SPD") for the Walmart Stores, Inc. Texas Injury Benefit Plan, effective March 1, 2012.

INJURY NOTICE AND MEDICAL PROVIDERS. I understand that if I am injured on the job, I must notify my supervisor within 24 hours of the time of the injury and receive any medical care from a Plan-approved physician within 14 days of my injury in order to receive benefits under the Plan.

SAFETY PLEDGE. I agree to familiarize myself with the safety program for my facility and to perform my job according to the Company and departmental safety rules. I will use any personal protective equipment that is provided to me. I will immediately report to my supervisor any accident that involves another associate, a customer, a vendor, or me. I will also immediately report any unsafe act, condition or equipment. I will cooperate with any accident investigations, and actively participate in any Employer safety training programs.

ARBITRATION. I acknowledge that this SPD includes a mandatory company policy requiring that **claims or disputes relating to the cause of an on-the-job injury (that cannot otherwise be resolved between the Employer and me) must be submitted to an arbitrator**, rather than a judge and jury in court. I understand that with notice and becoming employed (or continuing my employment) with the Employer at any time on or after March 1, 2012, I am accepting and agreeing to comply with these arbitration requirements. All covered claims brought by my spouse, children, parents, beneficiaries, representatives, executors, administrators, guardians, heirs or assigns are also subject to this arbitration policy, and any decision of an arbitrator will be final and binding on such persons and the Employer. **I understand that the arbitrator, and not a judge or jury, has the exclusive authority to resolve any dispute about the enforceability of this arbitration process.**

X _____ Associate's Signature	_____ Date
_____ Print Associate's Name	_____ Associate's Identification Number
_____ Parent or Legal Guardian Signature (If Associate under age 18)	_____ Date
_____ Print Parent or Legal Guardian Name	_____ Associate's Work Location or Department

INSTRUCTIONS TO ASSOCIATE OR GUARDIAN:

Once this form is completed, please fax to CMI at (479) 204-9790 or mail the original form to:

CMI
1025 W. Trinity Mills Road, Suite 120
Carrollton, TX 75006